Physician Related Services

Provided by:

Physicians, Mid-Level Practitioners, Podiatrists, Laboratories, Imaging Facilities, Independent Diagnostic Testing Facilities, and Public Health Clinics

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

July 2006

This publication supersedes all previous Physician, Mid-Level Practitioner, Podiatrist, Laboratory, Imaging Facility, Independent Diagnostic Testing Facility, and Public Health Clinic provider handbooks. Published by the Montana Department of Public Health & Human Services, July 2002.

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My Medicaid Provider ID Number:

My CHIP Provider ID Number:

MONTANA
Department of Public Health & Human Services

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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send e-mail inquiries to:
MTPRHelpdesk@ACS-inc.com

Send written inquiries to:
Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, PASSPORT questions, or to request provider manuals, fee schedules:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send e-mail inquiries to:
MTPRHelpdesk@ACS-inc.com

Send written inquiries to:
Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:
Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:
ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

PASSPORT Client Help Line

Clients who have general Medicaid questions may call the Client Help Line:

(800) 362-8312

Send written inquiries to:
PASSPORT To Health
P.O. Box 254
Helena, MT 59624-0254

PASSPORT Program Officer

Send inpatient stay documentation to:
PASSPORT Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Provider's Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the G*eneral Information For Providers* manual.

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-5283

CLIA Certification

For questions regarding CLIA certification, call or write:

(406) 444-1451 Phone
(406) 444-3456 Fax

Send written inquiries to:

DPHHS
Quality Assurance Division
Certification Bureau
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

Lab and X-ray

Public Health Lab assistance:

(800) 821-7284 In state
(406) 444-3444 Out of state and Helena

Send written inquiries to:

DPHHS Public Health Lab
1400 Broadway
P.O. Box 6489
Helena, MT 59620

Claims for multiple x-rays of same type on same day, send to:

DPHHS
Lab & X-ray Services
Health Policy & Services Division
P.O. Box 202951
Helena, MT 59620

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Send e-mail inquiries to:

MTEDIHelpdesk@ACS-inc.com

Mail to:

ACS
ATTN: MT EDI
P.O. Box 4936
Helena, MT 59604

Team Care Program Officer

For questions regarding the Team Care Program:

(406) 444-4540 Phone
(406) 444-1861 Fax

Team Care Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Nurse First

For questions regarding Nurse First Disease Management or the Nurse Advice Line, contact:

(406) 444-4540 Phone
(406) 444-1861 Fax

Nurse First Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Prior Authorization

The following are some of the Department's prior authorization contractors. Providers are expected to refer to their specific provider manual for prior authorization instructions.

Surveillance/Utilization Review

For prior authorization for certain services (see the *PASSPORT and Prior Authorization* chapter in this manual), contact SURS:

For clients with last names beginning with A - L, call:

(406) 444-3993 Phone

For clients with last names beginning with M - Z, call:

(406) 444-0190

Information may be faxed to:

(406) 444-0778 Fax

Send written inquiries to:
Surveillance/Utilization Review
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

First Health

For questions regarding prior authorization and continued stay review for selected mental health services.

(800) 770-3084 Phone
(800) 639-8982 Fax
(800) 247-3844 Fax

First Health Services
4300 Cox Road
Glen Allen, VA 23060

Mountain-Pacific Quality Health Foundation

For questions regarding prior authorization for out-of-state hospital services, transplant services, and private duty nursing services, or emergency department reveiws, contact:

Phone:
(800) 262-1545 X5850 In state
(406) 443-4020 X5850 Out of state and Helena

Fax:
(800) 497-8235 In state
(406) 443-4585 Out of state and Helena

Send written inquiries to:
Mountain-Pacific Quality
Health Foundation
3404 Cooney Drive
Helena, MT 59602

Key Web Sites

Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.mt.gov	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • **DPHHS:** Latest news and events, Mental Health Services Plan information, program information, office locations, divisions, resources, legal information, and links to other state and federal web sites. • **Health Policy and Services Division:** Children's Health Insurance Plan (CHIP), Medicaid provider information such as manuals, newsletters, fee schedules, and enrollment information.
Provider Information Website www.mtmedicaid.org	• Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts • Links to other websites and more
Client Information Website www.dphhs.mt.gov/hpsd/medicaid/medrecip/medrecip.htm	• Medicaid program information • Client newsletters • Who to call if you have questions • Client Notices & Information
Center for Disease Control and Prevention (CDC) web site www.cdc.gov/nip	Immunization and other health information
Parents Lets Unite for Kids (PLUK) www.pluk.org	This web site gives information on PLUK – an organization designed to provide support, training, and assistance to children with disabilities and their parents.
Medicaid Mental Health and Mental Health Services Plan www.dphhs.state.mt.us/about_us/divisions/addictive_mental_disorders/services/public_mental_health_services.htm	Mental Health Services information for Medicaid and MHSP

Key Web Sites (continued)

Web Address	Information Available
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this web-site for more information on: • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides
Washington Publishing Company www.wpc-edi.com	• EDI implementation guides • HIPAA implementation guides and other tools • EDI education

MONTANA
Department of Public Health & Human Services

Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for physicians, mid-level practitioners, podiatrists, public health clinics, independent laboratories, independent imaging facilities, and independent diagnostic testing facilities.

Each chapter has a section titled *Other Programs* that includes information about other Department programs such as the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP). Other essential information for providers is contained in the separate *General Information For Providers* manual. Each provider is asked to review both the general manual and the specific manual for his or her provider type.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of *Key Contacts* at the beginning of each manual. We have also included a space on the back side of the front cover to record your Medicaid Provider ID number for quick reference when calling Provider Relations.

Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through notices and replacement pages. When replacing a page in a manual, file the old pages in the back of the manual for use with claims that originated under the old policy. File all notices behind the tab marked "Notices."

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails. Links to rules are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office (see *Key*

Providers are responsible for knowing and following current laws and regulations.

Contacts). In addition to the general Medicaid rules outlined in the *General Information For Providers* manual, the following rules and regulations are also applicable to the physician related services programs:

- Code of Federal Regulations (CFR)
  - 42 CFR 410 Supplementary Medical Insurance (SMI) Benefits
  - 42 CFR 440 Services: General Provisions
  - 42 CFR 441 Services: Requirements and Limits Applicable to Specific Services
- Montana Codes Annotated (MCA)
  - MCA Title 37-2-101 - 37-2-313 General Provisions Relating to Health Care Practitioners
  - MCA 37-3-101 - 37-3-405 Medicine
  - MCA 37-6-101 - 37-6-312 Podiatry
  - MCA 37-14-101 - 37-14-102 Radiologic Technologists
  - MCA 37-34-101 - 37-34-307 Clinical Laboratory Science Practitioners
- Administrative Rules of Montana (ARM)
  - ARM 37.85.220 Independent Diagnostic Testing Facility
  - ARM 37.86.101 - 37.86.105 Physical Services
  - ARM 37.86.201 - 37.86.205 Mid-Level Practitioner Services
  - ARM 37.86.501 - 37.86.506 Podiatry Services
  - ARM 37.86.3201 - 37.86.3205 Non-Hospital Lab and Radiology (X-Ray) Services
  - ARM 37.86.1401 - 38.86.1406 Public Health Clinic Services

Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid provider's claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause (42 CFR 456.3).

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, provider relations, or a prior authorization unit). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information For Providers* manual also has a list of contacts for specific program policy information. Medicaid manuals, notices, replacement pages, fee schedules, forms, and much more are available on the *Provider Information* web site (see *Key Contacts*).

Covered Services

General Coverage Principles

Medicaid covers almost all services provided by physicians and mid-level practitioners, including preventive care. It also covers many services provided by podiatrists. This chapter provides covered services information that applies specifically to services performed by physicians, mid-level practitioners, podiatrists, physician and mid-level practitioner services within public health clinics, independent labs, independent imaging facilities, and independent diagnostic testing facilities. Like all health care services received by Medicaid clients, services provided by these practitioners must also meet the general requirements listed in the *Provider Requirements* chapter of the *General Information For Providers* manual.

Services within scope of practice (ARM 37.85.401)

Services are covered only when they are within the scope of the provider's license.

Services provided by physicians (ARM 37.86.101 – 105)

Physician services are those services provided by individuals licensed under their state medical practice act to practice medicine or osteopathy.

Services provided by mid-level practitioners (ARM 37.86.201 – 205)

Mid-level practitioners include physician assistants licensed to practice medicine by the Montana Board of Medical Examiners and advanced practice registered nurses licensed to practice medicine by the Montana Board of Nursing. Advanced practice registered nurses include nurse anesthetists, nurse practitioners, clinical nurse specialists, and certified nurse midwives. Mid-level practitioners also include practitioners outside Montana who hold appropriate licenses in their own states. Mid-level practitioners must bill under their own Medicaid ID number, rather than under a physician number. See the *Billing Procedures* chapter in this manual.

Services provided by podiatrists (ARM 37.86.501 – 506)

Podiatry services are those services provided by individuals licensed under state law to practice podiatry. Refer to *Routine podiatric care* in this chapter and the podiatrist fee schedule for specific covered services.

Services provided by independent laboratories (ARM 37.86.3201 - 3205)

Medicaid covers tests provided by independent (non-hospital) clinical laboratories when the following requirements are met:

- Services are ordered and provided by physicians, dentists, or other providers licensed within the scope of their practice as defined by law. Medicaid does not cover lab services ordered by chiropractors.
- Services are provided in an office or other similar facility, but not in a hospital outpatient department or clinic.
- Providers of lab services must be Medicare certified.
- Providers of lab services must have a current Clinical Laboratory Improvement Amendments (CLIA) certification number. CLIA certification may be obtained in Montana through the Department (see *Key Contacts)*.
- Medicaid does not cover reference lab services. Providers may bill Medicaid only for those lab services they have performed themselves. Modifier 90, used to indicate reference lab services, is not covered by Medicaid.

Services provided by independent imaging facilities (ARM 37.86.3201 - 3205)

Medicaid covers tests provided by independent (non-hospital) imaging facilities when the following requirements are met:

- Services are ordered and provided by physicians, dentists, or other providers licensed within the scope of their practice as defined by law.
- Services are provided in an office or similar facility, but not in a hospital outpatient department or clinic.
- Imaging providers must be supervised by a physician licensed to practice medicine within the state the services are provided.
- Imaging providers must meet state facility licensing requirements. Facilities must also meet any additional federal or state requirements that apply to specific tests, e.g., mammography. All facilities providing screening and diagnostic mammography services are required to have a certificate issued by the Federal Food and Drug Administration (FDA). For more information contact the FDA at (800) 838-7715.
- For most imaging services and some other tests, the fee schedules show different fees depending on whether the practitioner provided only the technical component (performing the test), only the professional component (interpreting the test), or both components (also known as the global service). Practitioners must bill only for services they provided.
- Technical components of imaging services must be performed by appropriately licensed staff (e.g., x-ray technician) operating within the scope of their practice as defined by state law and under the supervision of a physician.

Services provided by independent diagnostic testing facilities (ARM 37.85.220)

- Medicaid covers diagnostic testing services provided by independent diagnostic testing facilities (IDTF) under the supervision of a physician (see the IDTF fee schedule).
- Services may be performed in either a fixed location or mobile facility, but must be independent of a hospital.
- Before enrolling in Medicaid, IDTFs must be enrolled in Medicare.

Services provided by public health clinics (ARM 37.86.1401 – 1406)

- Public health clinic services are physician and mid-level practitioner services provided in a clinic designated by the Department as a public health clinic.
- Services must be provided directly by a physician or by a public health nurse under a physician's immediate supervision (i.e, the physician has seen the patient and ordered the service).
- Minimal services (see *Definitions*) are covered when provided by a registered nurse operating under protocols (see *Definitions*). These services do not require that the physician see the patient.

Non-covered services (ARM 37.85.207 and 37.86.205)

Some services not covered by Medicaid include the following:

- Acupuncture
- Naturopath services
- Services provided by surgical technicians who are not physicians or mid-level practitioners
- Services considered experimental or investigational
- Services provided to Medicaid clients who are absent from the state, with the following exceptions:
    - Medical emergency
    - Required medical services are not available in Montana. Prior authorization may be required; see the *PASSPORT and Prior Authorization* chapter in this manual.
    - If the Department has determined that the general practice for clients in a particular area of Montana is to use providers in another state
    - When out-of-state medical services and all related expenses are less costly than in-state services

- When Montana makes adoption assistance or foster care maintenance payments for a client who is a child residing in another state

- Medicaid does not cover services that are not direct patient care such as the following:
  - Missed or canceled appointments
  - Mileage and travel expenses for providers
  - Preparation of medical or insurance reports
  - Service charges or delinquent payment fees
  - Telephone services in home
  - Remodeling of home
  - Plumbing service
  - Car repair and/or modification of automobile

Importance of fee schedules

Use the current fee schedule for your provider type to verify coverage for specific services.

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. Fee schedules not only list Medicaid covered codes, but they also provide clarification of indicators such as whether a code requires prior authorization, can be applied to a co-surgery, or can be billed bilaterally, etc. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in this chapter. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service.

Current fee schedules are available on disk, hardcopy, or on the *Provider Information* web site (see *Key Contacts*). For disk or hard copy, contact Provider Relations (see *Key Contacts*).

Coverage of Specific Services

The following are coverage rules for specific services provided by physicians, mid-level practitioners and podiatrists.

Abortions (ARM 37.86.104)

Abortions are covered when one of the following conditions are met:

- The client's life would be endangered if the fetus is carried to term.
- The pregnancy is the result of rape or incest.
- The abortion is determined by the attending physician to be medically necessary, even if the client's life is not endangered if the fetus is carried to term.

A completed *Medicaid Recipient/Physician Abortion Certification* (MA-37) form must be submitted with every abortion claim or payment will be denied (see *Appendix A: Forms*). Complete only one part (I, II, or III) of this form; the part used must be clearly indicated on the form. This form is the only form Medicaid accepts for abortion services.

All forms required for abortions can be copied from *Appendix A Forms*, can be ordered using the *Medicaid Form Order* sheet in the *General Information For Providers* manual, or downloaded from the *Provider Information Web Site* (see *Key Contacts*).

When using mifepristone (Mifeprex or RU 486) to terminate a pregnancy, it must be administered within 49 days from the beginning of the last menstrual period by or under the supervision of a physician who:

- Can assess the duration of a pregnancy.
- Can diagnose ectopic pregnancies.
- Can provide surgical intervention in cases of incomplete abortion or severe bleeding, or can provide such care through other qualified physicians.
- Can assure access to medical facilities equipped to provide blood transfusion and resuscitation.
- Has read, understood and explained to the client the prescribing information for mifepristone.

Cosmetic services (ARM 37.86.104)

Medicaid covers cosmetic services only when it can be demonstrated that the condition has a severe detrimental effect on the client's physical and psychosocial wellbeing. Mastectomy and reduction mammoplasty services are covered only when medically necessary. Medical necessity for reduction mammoplasty is related to signs and symptoms resulting from macromastia. Medicaid covers surgical reconstruction following breast cancer treatment. Before cosmetic services are performed, they must be prior authorized (see the *PASSPORT and Prior Authorization* chapter in this manual). Services are authorized on a case-by-case basis.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) (ARM 37.86.2201 – 2221)

The Well Child EPSDT program covers all medically necessary services for children age 20 and under. Providers are encouraged to use a series of screening and diagnostic procedures designed to detect diseases, disabilities, and abnormalities in the early stages (see the *Well Child EPSDT* chapter in this manual). Some services are covered for children that are not covered for adults, such as the following:

- Nutritionist services
- Private duty nursing
- Respiratory therapy
- Therapeutic family and group home care
- Substance dependency inpatient and day treatment services
- School based services

All prior authorization and PASSPORT approval requirements must be followed. See the *PASSPORT and Prior Authorization* chapter in this manual.

Family planning services (ARM 37.86.1701)

Family planning services include the following:

- Initial visit
- Initial physical examination
- Comprehensive history
- Laboratory services
- Medical counseling
- Annual visits
- Routine visits

Medicaid covers prescription contraceptive supplies, implantation or removal of subcutaneous contraceptives, and fitting or removal of an IUD and fitting of a diaphragm. Approval by the PASSPORT provider is not required for family planning services. See the *Completing a Claim* chapter in this manual for PASSPORT indicators. Specific billing procedures must be followed for family planning services (see *Billing Procedures*).

Home obstetrics (ARM 37.85.207)

Home deliveries are only covered on an emergency basis (see *Definitions*) by a physician or licensed midwife.

Immunizations

The Vaccines For Children (VFC) Program makes available at no cost to providers selected vaccines for eligible children 18 years old and under. Medicaid will therefore pay only for the administration of these vaccines (oral or injection). VFC covered vaccines may change from year to year. For more information on the VFC program and current VFC covered vaccines, call the Department's Immunization Program at (406) 444-5580.

Medicaid does not cover pneumonia and flu vaccines for clients with Medicare Part B insurance because Medicare covers these immunizations.

Infertility (ARM 37.85.207)

Medicaid does not cover treatment of infertility.

Prescriptions (ARM 37.86.1102)

- Drugs are limited to a 34-day supply.
- No more than two prescriptions of the same drug may be dispensed in a calendar month except for the following:
  - Antibiotics
  - Schedule II and III drugs
  - Antineoplastic agents

- Compounded prescriptions
- Prescriptions for suicidal patients or patients at risk for drug abuse
- Topical preparations
- Propoxyphene, propoxyphene napsylate, and all propoxyphene combinations

- The DUE CARE board has set monthly limits on certain drugs. Use over these amounts requires prior authorization. Only one migraine medication may be prescribed within a month. Refer to the *PASSPORT and Prior Authorization* chapter in this manual for limits.

Routine podiatric care

Medicaid pays for routine podiatric care when a medical condition affecting the legs or feet (such as diabetes or arteriosclerosis obliterans) requires treatment by a physician or podiatrist. Routine podiatric care includes the following:

- Cutting or removing of corns and calluses
- Trimming of nails
- Application of skin creams
- Debridement of nails
- Other hygienic or preventive maintenance care

Sterilization (ARM 37.86.104)

Elective Sterilization

Elective sterilizations are sterilizations done for the purpose of becoming sterile. Medicaid covers elective sterilization for men and women when all of the following requirements are met:

1. Client must complete and sign the *Informed Consent to Sterilization* (MA-38) form at least 30 days, but not more than 180 days, prior to the sterilization procedure. This form is the **only** form Medicaid accepts for elective sterilizations (see *Appendix A Forms* for the form and instructions). If this form is not properly completed, payment will be denied.

   The 30-day waiting period may be waived for either of the following reasons:

   - **Premature Delivery**. The *Informed Consent to Sterilization* must be completed and signed by the client at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.
   - **Emergency Abdominal Surgery**. The *Informed Consent to Sterilization* form must be completed and signed by the client at least 72 hours prior to the sterilization procedure.

2. Client must be at least 21 years of age when signing the form.

All forms required for sterilizations can be copied form *Appendix A: Forms*, downloaded from the Provider Information Website, or ordered from Provider Relations (see *Key Contacts*).

Medicaid covers hysterectomies only when they are a result of a procedure performed to address another medical problem, not when the primary purpose is to render the client sterile.

3. Client must not have been declared *mentally incompetent* (see *Definitions*) by a federal, state or local court, unless the client has been declared competent to specifically consent to sterilization.

4. Client must not be confined under civil or criminal status in a correctional or rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill.

Before performing a sterilization, the following requirements must be met:

- The client must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction.
- The client must be informed of his/her right to withdraw or withhold consent anytime before the sterilization without being subject to retribution or loss of benefits.
- The client must be made aware of available alternatives of birth control and family planning.
- The client must understand the sterilization procedure being considered is irreversible.
- The client must be made aware of the discomforts and risks which may accompany the sterilization procedure being considered.
- The client must be informed of the benefits and advantages of the sterilization procedure.
- The client must know that he/she must have at least 30 days to reconsider his/her decision to be sterilized.
- An interpreter must be present and sign for those clients who are blind, deaf, or do not understand the language to assure the person has been informed.

Informed consent for sterilization may not be obtained under the following circumstances:

- If the client is in labor or childbirth.
- If the client is seeking or obtaining an abortion.
- If the client is under the influence of alcohol or other substance which affects his/her awareness.

A notation *"Not a Sterilization"* on a claim is not sufficient to fulfill these certification requirements.

Medically Necessary Sterilization

When sterilization results from a procedure performed to address another medical problem, it is considered a medically necessary sterilization. These procedures include hysterectomies, oophorectomies, salpingectomies and ochiectomies. Every claim submitted to Medicaid for a medically necessary sterilization must be accompanied by one of the following:

- A completed *Medicaid Hysterectomy Acknowledgement* form (MA- 39) for each provider submitting a claim. See *Appendix A Forms*. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (section B) or life-threatening emergency (section C) exists, the client (or representative, if any) and physician must sign and date section A of this form prior to the procedure (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). Also, for section A, signatures dated after the surgery date require manual review of medical records by the Department. The Department must verify that the client (and representative, if any) was informed orally and in writing, prior to the surgery, that the procedure would render the client permanently incapable of reproducing. The client does not need to sign this form when sections B or C are used. Please refer to *Appendix A* for more detailed instructions on completing the form.
- For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
    - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
    - The reason for the hysterectomy was a life-threatening emergency.
    - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

  When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (Eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

Surgical services

- The fee schedule shows Medicaid policies code by code on global periods, bilateral procedures, assistants at surgery, co-surgeons, and team surgery. These policies are almost always identical to Medicare policies but in cases of discrepancy the Medicaid policy applies.
- Medicaid only covers "assistant at surgery" services when provided by physicians or mid-level practitioners who are Medicaid providers.
- Medicaid does not cover surgical technician services.
- See the *Billing Procedures* chapter regarding the appropriate use of modifiers for surgical services.

Telemedicine services

- Medicaid covers telemedicine services when the consulting provider is enrolled in Medicaid.
- The requesting provider need not be enrolled in Medicaid nor be present during the telemedicine consult.
- Medicaid does not cover network use charges.

Transplants

All Medicaid transplant services must be prior authorized (see the *PASSPORT and Prior Authorization* chapter in this manual). Medicaid covers the following transplant services:

- For clients 21 years or older: only bone marrow, kidney, or cornea transplants.
- For clients less than 21 years old: all transplants that are covered by Medicare that are not considered experimental or investigational.

Weight reduction

- Physicians and mid-level practitioners who counsel and monitor clients on weight reduction programs can be paid for those services. If medical necessity is documented, Medicaid will also cover lab work. Similar services provided by nutritionists are not covered for adults.
- Medicaid does **not** cover the following weight reduction services:
  - Weight reduction plans or programs (e.g., Jenny Craig, Weight Watchers, etc.)
  - Nutritional supplements
  - Dietary supplements
  - Health club memberships
  - Educational services of a nutritionist
  - Gastric bypass

Emergency department visits

The Department covers emergency services provided in the emergency department. Emergency medical services are those services required to treat and stabilize an emergency medical condition. Beginning August 1, 2003, a service is reimbursed as an emergency if one of the following criteria is met:

- The service is billed with a CPT code of 99284 or 99285
- The client has a qualifying emergency diagnosis code. A list of the Department's pre-approved emergency diagnosis codes is available on the Provider Information website under *Emergency Diagnosis Codes* (see *Key Contacts*).

- The service did not meet one of the previous two requirements, but the medical professional rendering the medical screening and evaluation believes an emergency existed. In this case, the claim and documentation supporting the emergent nature of the services must be mailed to the emergency department review contractor (see *Key Contacts*).
- If the client is under two years old and is seen in the emergency room on a weekend or on January 1, July 4, or December 25, then the claim will be considered and processed as emergent.
- If the client is under two and is seen in the emergency room on a weekday outside of regular office hours, or on a holiday other than January 1, July 4, or December 25, and the claim contains procedure code 99050 (services requested after posted office hours in addition to basic service), then the claim will be considered and processed as an emergency.

If the visit does not meet one of the emergency criteria, then services beyond the screening and related diagnostic tests are not reimbursed and cost sharing should be collected. If the visit meets the emergency criteria, cost sharing is not collectible.

If an inpatient hospitalization is recommended as post stabilization treatment, the hospital must get a referral from the client's PASSPORT provider. If the hospital attempts to contact the PASSPORT provider and does not receive a response within 60 minutes, authorization is assumed. To be paid for these services, documentation that clearly shows the time of the attempt to reach the PASSPORT provider and the time of the initiation of post stabilization treatment must be sent to the PASSPORT program officer (see *Key Contacts*) for review. The documentation must include the time an attempt was made to reach the provider and the time the inpatient hospitalization began. There must be a 60 minute time lapse between these two events.

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

Clients who are enrolled in MHSP have limited coverage for physician-related services. See the *Mental Health Services Plan* manual.

For Medicaid clients seeking mental health services, the information in this chapter applies to mental health services just as it does for physical health services.

MONTANA
Department of Public Health & Human Services

Well Child EPSDT

Early and Periodic Screening, Diagnosis and Treatment is the federally sponsored, comprehensive health care benefits package for Medicaid-enrolled children through age 20. It helps families get early identification and treatment of medical, dental, vision, mental health and developmental problems for their children. All Medicaid families are encouraged to use these services.

EPSDT includes a medical screen (sometimes called a well child check-up), vision screen, dental screen and hearing screen for all Medicaid-enrolled children. There are four periodicity schedules, one each for well child screens, dental screens, vision screens, and hearing screens. These periodicity schedules are shown in Appendix B. These screens help spot and take care of health problems early in a child's growth. Each screen includes a detailed health and developmental history; a comprehensive, unclothed physical exam; age-appropriate immunizations and laboratory tests; and health education. The screens are provided at specific periods throughout a child's growth. See *Appendix B: Well Child Screen Chart* for specific recommendations for each age.

When a Medicaid-eligible child requires medically necessary services, those services may be covered under Medicaid even if they are not covered for adults. Health care, diagnostic services, treatments and other measures that would correct or improve defects or physical or mental illnesses or conditions are available based on medical necessity. If these services are not a "covered service" of Montana Medicaid, prior authorization is required. For more information on prior authorization, see the *Key Contacts* chapter of this manual.

The Well Child Screen

The foundation of Well Child EPSDT is the Well Child Screen. These screens should begin as early as possible in a child's life or as soon as the child is enrolled in Medicaid. The Well Child EPSDT program's Well Child Screens are based on a periodicity schedule established by medical, dental and other health care experts, including the American Academy of Pediatrics. The *Well Child Screen Recommendations* chart in *Appendix B* is designed for providers to copy and maintain for their records.

Montana Medicaid has initiated a project to improve provider awareness of the EPSDT program and the comprehensiveness of the well child screen. Beginning January 2006 an enhanced fee will be added to the reimbursement for well child screens. The Department will be conducting audits of medical records to ensure that the screens provided meet the expectations defined in this chapter.

Every infant should have a newborn evaluation after birth. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time. If a Well Child Screen shows that a child is "at risk" based on the child's environment, history, or test results, the provider should perform required or recommended tests even though they may not be indicated for the child's age. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

A. Initial/interval history

A comprehensive history, obtained from the parent or other responsible adult who is familiar with the child's history, should be done during the initial visit. Once it is done, it only needs to be updated at subsequent visits. The history should include the following:

- Developmental history to determine whether the child's individual developmental processes fall within a normal range of achievement compared to other children of his or her age and cultural background.
    - Discuss the child's development, as well as techniques to enhance the child's development, with the parents.
- Nutritional history and status. Questions about dietary practices indentify unusual eating habits, such as pica or extended use of bottle feedings, or diets which are deficient or excessive in one or more nutrients.
- Complete dental history.

B. Assessments

- ***Appropriate developmental screening.*** Providers should administer an age-appropriate developmental screen during each Well Child Screen. Results should be considered in combination with other information gained through the history, physical examination, observation, and reports of behavior. If developmental problems are identified, appropriate follow-up and/or referral to proper resources should be made.

  Speech and language screens identify delays in development. The most important readiness period for speech is 9 to 24 months. Parents should be urged to talk to their children early and frequently. Refer the child for speech and language evaluation as indicated.

  Parents of children with developmental disabilities should be encouraged to contact Parents Let's Unite for Kids (PLUK). PLUK is an organization designed to provide support, training, and assistance to children with disabilities and their parents. Visit the web site (see *Key Contacts*), or call or write:

PLUK
516 N. 32nd St.
Billings, MT 59101
(406) 255-0540 Phone
(800) 222-7585
(406) 255-0523 Fax

- ***Nutritional Screen.*** Providers should assess the nutritional status at each Well Child Screen. Children with nutritional problems may be referred to a licensed nutritionist or dietician for further assessment or counseling.
- ***Risk Assessment Screen.***
  - **Emotional.** Signs and symptoms of emotional disturbances represent deviations from or limitation in healthy development. These problems usually will not warrant a psychiatric referral but can be handled by the provider. He or she should discuss problems with parents and give advice. If a psychiatric referral is warranted, the provider should refer to an appropriate provider.
  - **Risky behaviors.** The provider should screen for risky behaviors (substance abuse, unprotected sexual activity, tobacco use, firearm possession, etc.). In most instances, indications of such behavior will not warrant a referral but can be handled by the provider. He or she should discuss the problems with the client and the parents and give advice. If a referral is warranted, the provider should refer to an appropriate provider.
  - **Blood lead.** Medicaid children should be **tested** for lead poisoning at 12 and 24 months of age. Children up to age 6 who have not been checked for lead poisoning before should also be tested. **All** children in Medicaid are at risk of lead poisoning. To ensure good health for the child, the federal government **requires** that all Medicaid children be tested. All Medicaid children at other ages should be screened.

    Complete a verbal risk assessment for all Medicaid children to age 6 at each EPSDT screening:

    - Does your child live in Butte, Walkerville or East Helena, which are designated high-risk areas?
    - Does your child live near a lead smelter, battery recycling plant, or other industry (operating or closed) likely to release lead?
    - Does your child live in or regularly visit a house built before 1960, which may contain lead paint?
    - Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?
    - Does your child live in a home where the plumbing consists of lead pipes or copper with lead solder joints?

Providers must use their medical judgment in determining applicability of performing specific test.

A blood lead level test should be performed on all children at 12 and 24 months of age.

- Does your child frequently come in contact with an adult who works with lead, such as construction, welding, pottery, reloading ammunition (making own bullets), etc.?
- Is the child given any home or folk remedies? If yes, discuss.

If the answers to all questions are negative, a child is considered at low risk for high doses of lead exposure. Children at **low risk** for lead exposure must receive a **blood test at 12 and 24 months.** If the answer to any question is positive, a child is considered at **high risk** for high doses of lead exposure and **a blood lead level test must be obtained immediately** regardless of the child's age.

- **Tuberculin.** Tuberculin testing should be done on individuals in high-risk populations or if historical findings, physical examination or other risk factors so indicate. High-risk populations include Asian refugees, Native American children, and migrant children.

C. Unclothed physical inspection

At each visit, a complete physical examination is essential. Infants should be totally unclothed and older children undressed and suitably draped.

D. Vision screen

A vision screen appropriate to the age of the child should be conducted at each Well Child Screen. If the child is uncooperative, rescreen within six months.

E. Hearing screens

A hearing screen appropriate to the age of the child should be conducted at each Well Child Screen. All newborns should be screened.

F. Laboratory tests

Providers who conduct Well Child Screens must use their medical judgment in determining applicability of performing specific laboratory tests. Appropriate tests should be performed on children determined "at risk" through screening and assessment.

- ***Hematocrit and hemoglobin.*** Hematocrit or hemoglobin tests should be done for "at risk" (premature and low birth weight) infants at ages newborn and 2 months. For children who are not at risk, follow the recommended schedule.
- ***Blood lead level.*** **All** children enrolled in Medicaid are at risk of lead poisoning. To ensure good health for the child, the federal government requires that all Medicaid children ages 12 and 24 months of age, or up to 72 months if not previously tested, should have a blood lead level test unless medically contraindicated. If an elevated blood level is discovered, a child should be retested every three to four months until lead levels are within normal limits, and then annually through 6 years of age. See page 3.3 for more details.

- ***Tuberculin screening.*** Tuberculin testing should be done on individuals in high-risk populations or if historical findings, physical examination or other risk factors so indicate. See page 3.4 for more details.
- ***Urinalysis.***
  - Because of heightened incidence of bacteriuria in girls, testing may be appropriate.
  - Children who have had previous urinary tract infections should be rescreened more frequently.
  - If test results are positive but the history and physical examination are negative, the child should be tested again in two weeks.
- ***STD screening.*** All sexually active clients should be screened for sexually transmitted diseases (STDs).
- ***Pelvic exam.*** All sexually active females, and all females 18 and over regardless of sexual activity, should have a pelvic exam. A pelvic exam and routine pap smear should be offered as part of preventive health maintenance.

G. Immunizations

- The immunization status of each child should be reviewed at each Well Child Screen. This includes interviewing parents or caretakers, reviewing immunization records, and reviewing risk factors.
- A checklist for a child's immunization regimen is provided in the W*ell Child Screen Recommendations* chart (*Appendix B*) for your convenience. The *Recommended Childhood Immunization* schedule is available on the *Provider Information web site* (see *Key Contacts*) and the *Centers for Disease Control and Prevention (CDC)* web site (see *Key Contacts*). This schedule is approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). The schedule on the website is updated as recommendations from the ACIP are received.
- If a child was not immunized at the recommended time, use the *Recommended Childhood Immunization* schedule to bring the child's immunizations current.

H. Dental screen

The child's dentist should perform annual dental screens, and results should be included in the child's initial/interval history. Other providers should perform an oral inspection, fluoride varnish (as available) and make a referral to a dentist for any of the following reasons:

- When the first tooth erupts and every six months thereafter.
- If a child with a first tooth has not obtained a complete dental examination by a dentist in the past 12 months.
- If an oral inspection reveals cavities, infection, or the child is developing a handicapping malocclusion or significant abnormality.

I. Discussion and counseling/Anticipatory guidance

Providers should discuss examination results, address assessed risks, and answer any questions in accordance with the parents' level of understanding. Age-appropriate discussion and counseling should be an integral part of each visit. Please allow sufficient time for unhurried discussions.

At each screening visit, provide age-appropriate anticipatory guidance concerning such topics as the following:

- Auto safety: Car seats, seat belts, air bags, positioning young or lightweight children in the backseat.
- Recreational safety: Helmets and protective padding, playground equipment.
- Home hazards: Poisons, accidental drownings, weapons, matches and lighters, staying at home alone, and use of detectors for smoke, radon gas, and carbon monoxide.
- Exposure to sun and secondhand smoke.
- Adequate sleep, exercise and nutrition, including eating habits and disorders.
- Peer pressure.
- General health: Immunizations, patterns of respiratory infections, skin eruptions, care of teeth.
- Problems such as stealing, setting fires, whining, etc. (as indicated by parental concern).
- Behavior and development: Sleep patterns, temper, attempts at independence (normal and unpleasant behavior), curiosity, speech and language, sex education and development, sexual activities, attention span, toilet training, alcohol and tobacco use, substance abuse.
- Interpersonal relations: Attitude of father; attitude of mother; place of child in family; jealousy; selfishness, sharing, taking turns; fear of strangers; discipline—obedience; manners—courtesy; peer companionship/relations; attention getting; preschool, kindergarten and school readiness and performance; use of money; assumption of responsibility; need for affection and praise; competitive athletics.

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PASSPORT and Prior Authorization

What Is PASSPORT, Team Care and Prior Authorization? (ARM 37.85.205 and 37.86.5101 - 5120)

PASSPORT To Health, the Team Care Program and prior authorization (PA) are examples of the Department's efforts to ensure the appropriate use of Medicaid services. In each case, providers need approval before services are provided to a particular client. PASSPORT approval and prior authorization are different, and some services may require both. A different code is issued for each type of approval and must be included on the claim form (see the *Completing A Claim* chapter in this manual).

- ***PASSPORT To Health Managed Care Program*** is Montana Medicaid's Primary Care Case Management (PCCM) Program. Under PASSPORT, Medicaid clients choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PASSPORT clients must be provided or approved by the PASSPORT provider. Most Montana Medicaid clients must participate in PASSPORT with only a few exceptions. The PASSPORT Program saves the Medicaid Program approximately $20 million each year. These savings allow improved benefits elsewhere in the Medicaid Program. For more information on PASSPORT To Health, see the *General Information For Providers* manual, *PASSPORT and Prior Authorization* chapter.
- ***Team Care*** is a utilization control and management program designed to educate clients on how to effectively use the Medicaid system. Clients with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. These clients must enroll in PASSPORT, select a PASSPORT primary care provider (PCP) and a single pharmacy, and call the Nurse First Advice Line prior to accessing Medicaid health services (except for emergency services). These clients receive extensive outreach and education from Nurse First nurses and are instructed on the proper use of the Montana Medicaid healthcare system. Team care is a component of the PASSPORT program, and all PASSPORT rules and guidelines apply to these clients. For more information on the Team Care Program and Nurse First, see the *General Information For Providers* manual or the *Team Care* page on the Provider Information website (see *Key Contacts*).
- ***Prior authorization*** refers to a list of services. If a service requires prior authorization, the requirement exists for all Medicaid clients. When prior authorization is granted, the provider is issued a PA number which must be on the claim. See *Prior Authorization* later in this chapter for instructions on how to obtain prior authorization for covered services.

Medicaid does not pay for services when prior authorization or PASSPORT requirements are not met.

Different codes are issued for PASSPORT approval and prior authorization, and both must be recorded on the claim form.

In practice, providers will most often encounter clients who are enrolled in PASSPORT. Specific services may also require prior authorization regardless of whether the client is a PASSPORT enrollee. Refer to *Prior Authorization* later in this chapter and the fee schedules for PA requirements. PASSPORT approval requirements are described below.

PASSPORT Information For All Providers

Client eligibility verification will indicate whether the client is enrolled in PASSPORT. The client's PASSPORT provider and phone number are also available, and the client may have full or basic coverage. Instructions for checking client eligibility are in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.

To be covered by Medicaid, all services must be provided in accordance with the requirements listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in the *Covered Services* chapter of this manual. Prior authorization and Team Care requirements must also be followed.

PASSPORT referral and approval

PASSPORT providers refer Medicaid clients for medically necessary services that they do not provide. Referrals can be made to any other provider who accepts Montana Medicaid. Referrals may be verbal or in writing, and must be accompanied by the primary care provider's PASSPORT number. The following services do not require PASSPORT approval:

Services That Do Not Require PASSPORT Provider Approval (by Provider Type)

Ambulance	Nursing facilities
Audiologists	Nursing facilities for the aged mentally retarded
Dentists (some services require authorization)	Optometrists and ophthalmologists
Dialysis	Personal assistance services in a client's home
Durable medical equipment	Pharmacies
Eyeglass providers	Podiatrists
Hearing aid providers	Psychologists
Home and community based service providers	Residential treatment centers
Home infusion therapy providers	Social workers (licensed)
Hospice providers	Substance dependency (non-hospital inpatient, outpatient, and day treatment providers)
Hospital swing bed	Targeted case management providers
Intermediate care facilities for the mentally retarded	Therapeutic family care
Laboratory service providers	Therapeutic group home care
Licensed clinical professional counselors	Transportation (commercial and specialized non-emergency)
Mental health case management providers	X-ray providers
Mental health centers	Outpatient hospital emergency department services

Some physician-related services also do not require PASSPORT provider approval:

- Anesthesiology
- Family planning
- Obstetrics
- Outpatient hospital emergency department services

Well Child EPSDT clients (all Medicaid clients under age 21) do not need PASSPORT provider approval for the following specific services:

- Immunizations
- Blood lead testing

PASSPORT and emergency services

PASSPORT provider approval is not required for emergency services. However, if an inpatient hospitalization is recommended as post stabilization treatment, see *Emergency department visits* in the *Covered Services* chapter of this manual for requirements.

Complaints and grievances

Providers may call Provider Relations (see *Key Contacts*) to report a complaint that something inappropriate has taken place. A grievance is a written complaint and must be addressed to the PASSPORT Program Officer (see *Key Contacts*).

PASSPORT and Indian Health Services

Clients who are eligible for both Indian Health Services (IHS) and Medicaid may choose IHS or another provider as their PASSPORT provider. Clients who are eligible for IHS do not need a referral from their PASSPORT provider to obtain services from IHS. However, if IHS refers the client to a non-IHS provider, the PASSPORT provider must approve the referral.

Getting questions answered

The *Key Contacts* list (at the front of this manual) provides important phone numbers and addresses. Provider and Client HelpLines are available to answer almost any PASSPORT or general Medicaid question. You may call the PASSPORT Provider HelpLine to obtain materials for display in your office, discuss any problems or questions regarding your PASSPORT clients, or enroll in PASSPORT. You can keep up with changes and updates to the PASSPORT program by reading the PASSPORT provider newsletters. Newsletters and other information is available on the *Provider Information* web site (see *Key Contacts*). For claims questions, call Provider Relations.

When Your Client Is Enrolled in PASSPORT (And You Are Not the PASSPORT Provider)

To be covered by Medicaid, all services must be provided in accordance with the requirements listed in the *Provider Requirements* chapter of the *General Information For Providers* manual, and in the *Covered Services* chapter of this manual. Prior authorization and Team Care requirements must also be followed.

- If a client is enrolled in PASSPORT, the services must be provided or approved by the client's PASSPORT provider. Some exceptions to this requirement are described in the *PASSPORT referral and approval* section earlier in this chapter.
- The PASSPORT provider's approval may be verbal or written but must be documented and maintained in the client's file, and the claim must contain the PASSPORT provider's PASSPORT number. Documentation should not be submitted with the claim.
- The client's PASSPORT provider must be contacted for approval for each visit. Using another provider's PASSPORT number without approval is considered fraud.
- If a PASSPORT provider refers a client to you, do not refer that client to someone else without the PASSPORT provider's approval, or Medicaid will not cover the service.
- To verify client eligibility, see the *Client Eligibility* chapter in the *General Information For Providers* manual.

Role of the PASSPORT Provider

PASSPORT providers manage a client's health care in several ways:

- Provide primary care, including preventive care, health maintenance, and treatment of illness and injury.
- Coordinate the client's access to medically necessary specialty care and other health services. Coordination includes referral, authorization, and follow-up.
- Authorize inpatient admissions.
- Provide or arrange for qualified medical personnel to be accessible 24 hours a day, 7 days a week to provide direction to clients in need of emergency care.
- Provide or arrange for suitable coverage for needed services, consultations, and approval of referrals during the provider's normal hours of operation.
- Provide or arrange for Well Child Check Ups and immunizations according to the periodicity schedule in the *Well Child EPSDT* chapter and *Appendix B* of this manual.
- Maintain a unified medical record for each PASSPORT client. This must include a record of all approvals for other providers. Providers must trans-

fer a copy of the client's medical record to a new primary care provider if requested in writing by the client.

- Review PASSPORT utilization rates (supplied by Medicaid) and analyze factors contributing to unusually high or low rates.

Providing PASSPORT referral and authorization

- Before referring a PASSPORT client to another provider, verify that the provider accepts Medicaid.
- When referring a client to another provider, you must give that provider your PASSPORT number.
- All referrals must be documented in the client's medical record or a telephone log. Documentation should not be submitted with the claim.
- PASSPORT approval may be for a one-time visit, a time-specific period, or the duration of an illness or pregnancy, as determined by the PASSPORT provider.

Client disenrollment

A provider can ask to disenroll a PASSPORT client for any reason including:

- The provider-client relationship is mutually unacceptable.
- The client fails to follow prescribed treatment (unless this lack of compliance is a symptom of the medical condition).
- The client is abusive.
- The client could be better treated by a different type of provider, and a referral process is not feasible.

Providers cannot terminate a provider-client relationship in mid-treatment. To disenroll a client, write to PASSPORT To Health (see *Key Contacts*). Providers must continue to provide PASSPORT management services to the client while the disenrollment process is being completed.

Termination of PASSPORT agreement

To terminate your PASSPORT agreement, notify PASSPORT To Health in writing at least 30 days before the date of termination. Termination is effective on the first day of the month following notice of termination, or the first day of the second month following notice of termination, whichever allows a 30 day time period to elapse.

Utilization review

PASSPORT providers' utilization patterns are analyzed on a regular basis. When a provider's average rates for service utilization are consistently high or low, the provider may be asked to furnish information regarding unusual practice patterns.

Caseload limits

PASSPORT providers may serve as few as one or as many as 1,000 Medicaid clients. Group practices and clinics may serve up to 1,000 clients for each full-time equivalent provider.

How to Become a PASSPORT Provider

Any provider who has primary care within his or her scope of practice and is practicing primary care can be a PASSPORT provider. PASSPORT providers receive a monthly case management fee of $3.00 for each enrolled PASSPORT client. Providers who wish to become a PASSPORT provider must:

- Enroll in Medicaid (contact *Provider Enrollment*). For more information on enrollment, see the *General Information For Providers* manual and enrollment forms available on the *Provider Information* web site (see Key Contacts).
- Call the PASSPORT Provider HelpLine at (800) 480-6823.

PASSPORT Tips

- View the client's Medicaid eligibility verification at each visit using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.
- Do not bill for case management fees; they are paid automatically to the provider each month.
- If you are not your client's PASSPORT provider, include the PASSPORT provider's PASSPORT approval number on the claim, or it will be denied.
- The same cost sharing, service limits, and provider payment rules apply to PASSPORT and non-PASSPORT clients and services.
- For claims questions, refer to the *Billing Procedures* chapter in this manual, or call Provider Relations (see *Key Contacts*).

Prior Authorization

Some services require prior authorization (PA) before providing them. When seeking PA, keep in mind the following:

- The referring provider should initiate all authorization requests.
- Always refer to the current Medicaid fee schedule to verify if PA is required for specific services.

- The following table (*PA Criteria for Specific Services*) lists services that require PA, who to contact, and specific documentation requirements. For more details on each service listed in the following table, please contact the prior authorization contact listed.
- For a list of prescription drugs that require PA, see the *PA Criteria for Prescription Drugs* table later in this chapter.
- Have all required documentation included in the packet before submitting a request for PA (see the following *PA Criteria for Specific Services* table for documentation requirements).
- Prior authorization criteria forms for most services are available on the Provider Information website (see Key Contacts)
- When PA is granted by the Surveillance/Utilization Review Section, providers will receive notification from both the Quality Assurance Divison and the Claims Processing Unit. The *Prior Authorization Notice* from the Claims Processing Unit will have a PA number. This PA number must be included on the claim.

PA Criteria for Specific Services

Service	PA Contact	Documentation Requirements

• **All transplant services**
• **Out-of-state hosptial inpatient services**
• **All rehab services**
	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In/out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In/out-of-state
		• Required information includes:
		  • Client's name
		  • Client's Medicaid ID number
		  • State and hospital where client is going
		  • Documentation that supports medical necessity. This varies based on circumstances. Mountain-Pacific Quality Health Foundation will instruct providers on required documentation on a case-by-case basis.

• **Transportation (scheduled ambulance transport, commercial and specialized non-emergency transportation)**
 	
(For emergency ambulance transport services, providers have 60 days following the service to obtain authorization.)
	Mountain-Pacific Quality Health Foundation
	Medicaid Transportation
	P.O. Box 6488
	Helena, MT 59604
	
	Phone:
	(800) 292-7114
	Fax:
	(800) 291-7791
	E-Mail:
	ambulance@mpqhf.org
		• Ambulance providers may call, leave a message, fax, or E-mail requests.
		• Required information includes:
		  • Name of transportation provider
		  • Provider's Medicaid ID Number
		  • Client's name
		  • Client's Medicaid ID number
		  • Point of origin to the point of destination
		  • Date and time of transport
		  • Reason for transport
		  • Level of services to be provided during transport (e.g., BLS, ALS, mileage, oxygen, etc.)
		• Providers must submit the trip report and copy of the charges for review after transport.
		• For commercial or private vehicle transportation, clients call and leave a message, or fax travel requests prior to traveling.

• **Eye prosthesis** • **New technology codes (Category III CPT codes)** • **Other reviews referred by Medicaid program staff**	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953 **Phone:** For clients with last names beginning with **A - L**, call: (406) 444-3993 In/out-of-state For clients with last names beginning with **M - Z**, call: (406) 444-0190 In/out-of-state **Fax:** (406) 444-0778	• Documentation that supports medical necessity • Documentation regarding the client's ability to comply with any required after care • Letters of justification from referring physician • Documentation should be provided at least two weeks prior to the procedure date.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Circumcision**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Circumcision requests are reviewed on a case-by-case basis based on medical necessity when one of the following occurs:
		  • Client has scarring of the opening of the foreskin making it non-retractable (pathological phimosis). This is unusual before five years of age. The occurrence of phimosis must be treated with non-surgical methods (i.e., topical steroids) before circumcision is indicated.
		  • Documented recurrent, troublesome episodes of infection beneath the foreskin (balanoposthitis) that does not respond to other non-invasive treatments and/or sufficient hygiene
		  • Urinary obstruction
		  • Urinary tract infections

• **Dispensing and fitting of contact lenses**	Provider Relations
	P.O. Box 4936
	Helena, MT 59604
	
	Phone:
	(406) 442-1837 In/out-of-state
	(800) 624-3958 In state
		• PA required for contact lenses and dispensing fees.
		• Diagnosis must be one of the following:
		  • Keratoconus
		  • Aphakia
		  • Sight cannot be corrected to 20/40 with eyeglasses

• **Prescription Drugs** (For a list of drugs that require PA, refer to the *PA Criteria for Prescription Drugs later in this chapter.*)	Drug Prior Authorization Unit Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602 **Phone:** (406) 443-6002 Helena (800) 395-7961 In/out-of-state **Fax:** (406) 443-7014 Helena (800) 294-1350 In/out-of-state	• Refer to the *PA Criteria for Prescription Drugs* table in this chapter for a list of drugs that require PA. • Providers must submit the information requested on the *Request for Drug Prior Authorization Form* to the Drug Prior Authorization Unit. This form is in *Appendix A: Forms*. • The prescriber (physician, pharmacy, etc.) may submit requests by mail, telephone, or FAX to the address shown on the *PA Criteria for Specific Services* table.

• **Maxillofacial / Cranial Surgery**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Surgical services are only covered when done to restore physical function or to correct physical problems resulting from:
		  • Motor vehicle accidents
		  • Accidental falls
		  • Sports injuries
		  • Congenital birth defects
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		• Medicaid does not cover these services for the following:
		  • Improvement of appearance or self-esteem (cosmetic)
		  • Dental implants
		  • Orthodontics

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Blepharoplasty**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Reconstrutive blepharoplasty may be covered for the following:
		  • Correct visual impairment caused by drooping of the eyelids (ptosis)
		  • Repair defects caused by trauma-ablative surgery (ectropion/entropion corneal exposure)
		  • Treat periorbital sequelae of thyroid disease and nerve palsy
		  • Relieve painful symptoms of blepharospasm (uncontrollable blinking).
		• Documentation must include the following:
		  • Surgeon must document indications for surgery
		  • When visual impairment is involved, a reliable source for visual-field charting is recommended
		  • Complete eye evaluation
		  • Pre-operative photographs
		• Medicaid does not cover cosmetic blepharoplasty

• **Botox Myobloc**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• For more details on botox criteria, coverage, and limitations, visit the Provider Information website (see *Key Contacts*)
		• Botox is covered for treating the following:
		Laryngeal spasm; Blepharospasm; Hemifacial spasm of the nerve; Torticollis, unspecified; Torsion dystonia; Fragments of dystonia; Hereditary spastic paraplegia; Multiple Sclerosis; Spastic hemiplegia; Infantile cerebral palsy; Other specified infantile cerebral palsy; Achalasia and cardiospasm; Spasm of muscle; Hyperhidrosis; Strabismus and other disorders of binocular eye movements; Other demyelinating diseases of the central nervous system
		• Documentation requirements include a letter from the attending physician supporting medical necessity including:
		  • Client's condition (diagnosis)
		  • A statement that traditional methods of treatments have been tried and proven unsuccessful
		  • Proposed treatment (dosage and frequency of injections)
		  • Support the clinical evidence of the injections
		  • Specify the sites injected
		• Myobloc is reviewed on a case-by-case basis

• **Excising Excessive Skin and Subcutaneous Tissue**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Required documentation includes the following:
		  • The referring physician and surgeon must document, in the history and physical, the justification for the resection of skin and fat redundancy following massive weight loss.
		  • The duration of symptoms of at least six months and the lack of success of other therapeutic measures
		  • Pre-operative photographs
		• This procedure is contraindicated for, but not limited to, individuals with the following conditions:
		  • Severe cardiovascular disease
		  • Severe coagulation disorders
		  • Pregnancy
		• Medicaid does not cover cosmetic surgery to reshape the normal structure of the body or to enhance a client's appearance.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Rhinoplasty Septorhinoplasty**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• The following do not require PA:
		  • Septoplasty to repair deviated septum and reduce nasal obstruction
		  • Surgical repair of vestibular stenosis to repair collapsed internal valves to treat nasal airway obstruction
		• Medicaid covers rhinoplasty in the following circumstances:
		  • To repair nasal deformity caused by a cleft lip/cleft palate deformity for clients 18 years of age and younger
		  • Following a trauma (e.g. a crushing injury) which displaced nasal structures so that it causes nasal airway obstruction.
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		• Not covered
		  • Cosmetic rhinoplasty done alone or in combination with a septoplasty
		  • Septoplasty to treat snoring

• **Temporomandibular Joint (TMJ) Arthroscopy / Surgery**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Non-surgical treatment for TMJ disorders must be utilized **first** to restore comfort, and improve jaw function to an acceptable level. Non-surgical treatment may include the following in any combination depending on the case:
		  • Fabrication and insertion of an Intra-oral Orthotic
		  • Physical therapy treatments
		  • Adjunctive medication
		  • Stress management
		• Surgical treatment may be considered when both of the following apply:
		  • Other conservative treatments have failed (must be documented), and chronic jaw pain and dysfunction have become disabling. Conservative treatments must be utilized for six months before consideration of surgery.
		  • There are specific, severe structural problems in the jaw joint. These include problems that are caused by birth defects, certain forms of internal derangement caused by misshapen discs, or degenerative joint disease. For surgical consideration, arthrogram results must be submitted for review.
		• Not covered:
		  • Botox injections for the treatment of TMJ is considered experimental.
		  • Orthodontics to alter the bite
		  • Crown and bridge work to balance the bite
		  • Bite (occlusal) adjustments

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Dermabrasion / Abrasion Chemical peel**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Services covered for the following:
		  • Treating severe, deep acne scarring not responsive to conservative treatment. All conservative treatments must have been attempted and documented for at least six months before medical necessity is determined.
		  • The removal of pre-cancerous skin growths (keratoses)
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		  • Pre-operative photographs

• **Positron Emission Tomography (PET) Scans**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• PET scans are covered for the following clinical conditions: (For more details on each condition and required documentation, contact the SURS unit.)
		  • Solitary pulmonary nodules (SPNs) - characterization
		  • Lung cancer (non small cell) - Diagnosis, staging, restaging
		  • Esophageal cancer - Diagnosis, staging, restaging
		  • Colorectal cancer - Diagnosis, staging, restaging
		  • Lymphoma - Diagnosis, staging, restaging
		  • Melanoma - Diagnosis, staging, restaging. Not covered for evaluating regional nodes
		  • Breast cancer - As an adjunct to standard imaging modalities for staging clients with distant metastasis or restaging clients with locoregional recurrence or metastasis; as an adjunct to standard imaging modalities for monitoring tumor response to treatment for women with locally and metastatic breast cancer when a change in therapy is anticipated
		  • Head and neck cancers (excluding CNS and thyroid) - Diagnosis, staging, restaging
		  • Myocardial Viability - Primary or initial diagnosis, or following an inconclusive SPECT prior to revascularization. SPECT may not be used following an inconclusive PET scan.
		  • Refractory Seizures - Covered for pre-surgical evaluation only.
		  • Perfusion of the heart using Rubidium 82 tracer (Not DFG-PET) - Covered for noninvasive imaging of the perfusion of the heart.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Reduction Mammoplasty**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT
	59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/ out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/ out-of-state
	
	Fax:
	(406) 444-0778
		• Both the Referring physician and the surgeon must submit documentation.
		• Back pain must have been documented and present for at least six months, and causes other than weight of breasts must have been excluded.
		• **Indications for female client:**
		• Contraindicated for pregnant women and lactating mothers. A client must wait six months after the cessation of breast feeding before requesting this procedure.
		• Female client 16 years or older with a body weight less than 1.2 times the ideal weight.
		• There must be severe, documented secondary effects of large breasts, unresponsive to standard medical therapy administered over at least a six month period. This must include at least two of the following conditions:
		  • Upper back, neck, shoulder pain that has been unresponsive to at least six months of documented and supervised physical therapy and strengthening exercises
		  • Paresthesia radiating into the arms. If parathesia is present, a nerve conduction study must be submitted.
		  • Chronic intertrigo (a superficial dermatitis) unresponsive to conservative measures such as absorbent material or topical antibiotic therapy. Document extent and duration of dermatological conditions requiring antimicrobial therapy.
		  • Significant shoulder grooving unresponsive to conservative management with proper use of appropriate foundation garments which spread the tension of the support and lift function evenly over the shoulder, neck and upper back.
		Documentation in the client's record must indicate and support the following:
		• History of the client's symptoms related to large, pendulous breasts.
		• The duration of the symptoms of at least six months and the lack of success of other therapeutic measures (e.g., documented weight loss programs with six months of food and calorie intake diary, medications for back/neck pain, etc.).
		• Guidelines for the anticipated weight of breast tissue removed from each breast related to the client's height (which must be documented):
		Height — **Weight of tissue per breast**
		less than 5 feet — 250 grams
		5 feet to 5 feet, 2 inches — 350 grams
		5 feet, 2 inches to 5 feet, 4 inches — 450 grams
		greater than 5 feet, 4 inches — 500 grams
		• Pre-operative photographs of the pectoral girdle showing changes related to macromastia.
		• Medication use history. Breast enlargements may be caused by various medications (e.g., sironolactone, cimetidine) or illicit drug abuse (e.g., marijuana, heroin, steroids). Although rare in women, drug effects should be considered as causes of breast enlargement prior to surgical treatment since the problem may recur after the surgery if the drugs are continued. Increased prolactin levels can cause breast enlargement (rare). Liver disease, adrenal or pituitary tumors may also cause breast enlargement and should also be considered prior to surgery.
		• **Indications for male client:**
		• If the condition persists, a client may be considered a good candidate for surgery. Clients who are alcoholic, illicit drug abusers (e.g., steroids, heroin, marijuana) or overweight are not good candidates for the reduction procedure until they attempt to correct their medical problem first.
		• Documentation required: length of time gynecomastia has been present, height, weight, and age of the client, pre-operative photographs

PA Criteria for Medicaid Prescription Drugs

Drug	Criteria
Actiq Lozenges (fentanyl)	• No history of MAOI use within the last 30 days • Initial doses greater than 200mcg will not be approved. Initial therapy will be defined as patients not having Actiq therapy in the last 30 days • Non-cancer diagnoses will not be approved • Greater usage than 4 units of any strength per day • Authorization for existing usage in pain of non-cancer origin will be granted on an individual basis in consultation with the prescriber to prevent withdrawal syndromes.
Aggrenox (aspirin/dipyridamole)	For prevention of recurrent stroke in patients who have experienced a transient ischemic attack or previous ischemic stroke and who have had a recurrent stroke while on aspirin or have failed plavix.
Antiemetics Kytril Tablets and oral solution. PA required for quantities greater than 10 units in a 30-day period. Zofran Tablets and oral solution. PA required for quantities greater than 15 units in a 30-day period. Anzemet Tablets PA required for quantities greater than 5 units in a 30-day period.	For prescription exceeding monthly quantity limits for the prevention of nausea and vomiting associated with chemotherapy/radiation therapy, or for nausea and vomiting associated with pregnancy when traditional therapies have failed. Quantity limits for these and other indications will be considered on a case by case basis.
Antipsychotics Zyprexa Zydis (olanzapine) Risperdal M-tabs (risperidone)	Patients who have special requirements for administration of atypical antipsychotics may be granted prior authorization for these two formulations of Zyprexa and Risperdal.
Risperdal Consta (risperidone)	Prior authorization for Risperdal Consta, a long acting injectable form of Risperdal, requires that the patient must have tried and failed the oral Risperdal or have documented compliance issues.
Avinza (Morphine sulfate extended-release capsules) PA required for quantities greater than once daily.	Requests exceeding these quantity limits will be considered on an individual basis.

PA Criteria for Medicaid Prescription Drugs (continued)

Drug	Criteria
COX-2 Inhibitors Celebrex (celecoxib) Bextra (valdecoxib)	No history of aspirin sensitivity or allergy to aspirin or other NSAID, and/or aspirin triad, and at least one of the following: • History of previous GI bleeding within the last 5 years • Current or recurrent gastric ulceration • History of NSAID-induced gastropathy • Currently treated for GERD • For clients 65 years of age • Currently on anticoagulant therapy
Dipyridamole	As adjunct to warfarin anticoagulants in the prevention of postoperative thromboembolic complications of cardiac valve replacement.

Disease-Modifying Anti-Rheumatic Drugs (DMARD)
 	
Arava (leflunomide)
Enbrel (etanercept)
Humira (adalimumab)
Kineret (anakinra)
Remicade (infliximab)
	• Diagnosis of rheumatoid arthritis
	• Rheumatology consult with date and copy of consult included
	• Kineret may be used alone or in combination with DMARD's other than tumor necrosis factor (TNF) blocking agents (i.e. Enbrel)
	  • Enbrel whether alone or in combination with methotrexate.
	  • Enbrel or Remicade may be approved with Arava on an individual basis.
	  • Remicade when used in combination with methotrexate may be approved for first-line treatment in patients with moderately to severely active rheumatoid arthritis as evidenced by:
	  • > 10 swollen joints
	  • $\geq$ 12 tender joints
	  • Elevated serum rheumatoid factor levels or erosions on baseline x-rays
	  • Remicade therapy will only be approved following a negative
	  • TB test
	  • Enbrel also covered for psoriasis when accompanied by a prescription from a dermatologist.

Remicade (infliximab)	Also covered for the following diagnoses: • Moderately to severely active Crohn's disease for patients with an inadequate response to conventional therapy • Fistulizing Crohn's disease
Erectile Dysfunction Viagra (sildenafil) Cialis (tadalafil) Levitra (vardenafil) Quantity limited to one (1) tablet per month	• Diagnosis of erectile dysfunction. • Males only, 18 years of age or older. • No concomitant organic nitrate therapy.

PA Criteria for Medicaid Prescription Drugs (continued)

Drug	Criteria
Gastro-intestinal drugs Includes H-2 antagonists, proton pump inhibitors, and Cytotec Prior authorization is required only for concomitant usage of an H2-antagonist and a proton pump inhibitor. This PA requirement is designed to avoid therapeutic duplications.	Diagnosis of: • Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas) • Symptomatic gastroesophageal reflux (not responding or failure of maintenance therapy) • Symptomatic relapses (duodenal or gastric ulcer) on maintenance therapy • Barretts esophagus • GERD Other conditions considered on an individual basis.
Growth hormones	Diagnosis of: • Growth hormone deficiency in children and adults • Growth retardation of chronic renal insufficiency • Turner's Syndrome • AIDS-related wasting Children and adolescents must meet the following criteria: • Standard deviation of 2.0 or more below mean height for chronological age • No expanding intracranial lesion or tumor diagnosed by MRI • Growth rate below five centimeters per year • Bone age 14-15 years or less in females and 15-16 years or less in males • Epiphyses open **Growth hormone deficiency in children:** Failure of any two stimuli tests to raise the serum growth hormone level above 10 nanograms/ milliliter. **Growth retardation of chronic renal insufficiency:** Irreversible renal insufficiency with a creatinine clearance <75 ml/min per 1.73m^2 but pre-renal transplant. Turner's Syndrome: Chromosomal abnormality showing Turner's syndrome. Growth hormone deficiency in adults: • **Adult Onset:** Patients have somatotropin deficiency syndrome (SDS) either alone or with multiple hormone deficiencies, (hypopituitarism), as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma. • **Childhood Onset:** Patients who had growth hormone deficient during childhood and now have somatotropin deficiency syndrome (SDS).

PA Criteria for Medicaid Prescription Drugs (continued)

Drug	Criteria
Hypnotic Drugs Ambien (zolpidem) Sonata (zaleplon) Quantity limited to 15 tablets per month.	Trial and failure with at least <u>two</u> multi-source prescription sleep-inducing drugs.
Migraine Headache Drugs For monthly quantities greater than 9 tablets: Imitrex (sumatriptan): 4 injections (2 kits) **or** 6 units of nasal spray Maxalt (rizatriptan) Zomig (zolmitriptan) and Zomig ZMT (zolmitriptan) Zomig nasal spray 6 units Migranal (dihydroergotamine): 4 units Axert (almotriptan) Frova (frovatriptan) Relpax (electriptan) Amerge (naratriptan HCl)	Indicated only for treatment of <u>acute</u>, migraine/cluster headache attacks for patients who meet the following criteria: • No history of, or signs or symptoms consistent with, ischemic heart disease (angina pectoris, history of MI or documented silent ischemia) or Prinzmetal's angina • No uncontrolled hypertension • No complicated migraine including vertebrobasilar migraine • Not pregnant • No use of ergotamine-containing medication(s) within previous 24-hours • No use of MAOI within previous 2-weeks • Non-responsive to NSAIDS, acetaminophen, combination analgesics (isometheptene, butalbital, +/- metoclopramide), or ergot derivatives, or these medications are contraindicated Usage of duplicating generic entities are not allowed, but authorization may be approved on an individual basis for concomitant use of differing dosing formulations of the same drug. Concurrent therapy with Stadol will not be covered.
Nonsedating antihistamine products	• Prescribed OTC Loratadine products whose manufacturer has a rebate agreement with the Centers for Medicare and Medicaid Services (CMS) will be available to clients without prior authorization (PA) restrictions. • PA required for federal legend brand and generic non-sedating antihistamines. PA may be authorized upon failure of a fourteen day trial of OTC Loratadine products
Nonsteroidal Anti-Inflammatory Drugs (NSAIDS) PA required for all single-source NSAIDS: Ponstel Mobic Naprelan	Trial and failure with at least <u>two</u> multiple-source products must be documented.
Oxycodone HCL Controlled-Release (OxyContin)	Prior authorization is required for all dosing above twice a day and above 320 mg per day.

PA Criteria for Medicaid Prescription Drugs (continued)

Drug	Criteria
Pletal (cilostazol) For greater than 12-week supply within a 12-month period.	• Diagnosis of intermittent claudication as the result of chronic occlusive arterial disease (COAD) of the lower limbs. Possible causes of COAD include: arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's disease), arteritis, trauma, congenital arterial narrowing, or other forms of peripheral vascular disease resulting in chronic vascular occlusion in the legs; **and** • The patient has shown clinical improvement in their COAD while on pentoxifylline or cilostazol. • Considered on an individual basis when pentoxifylline or cilostazol is being used as part of a standardized treatment protocol, e.g. bone marrow or oncology treatment protocols.
Proton Pump Inhibitors (PPI's) Prevacid NapraPac	Federal legend, brand and generic Proton Pump Inhibitors (PPI's) may be authorized upon failure of Prilosec OTC 20mg at doses that exceed 40mg per day. Special consideration may be given on an individual basis for patients requiring specific dosing regimens based on the various PPI formulations. Requires that the patient must have tried and failed concomitant use of Prilosec OTC and Naproxen.
Smoking Cessation Drugs Nicotine-replacement products. Patches are the preferred course of therapy. The gum, lozenge and inhaler replacement therapies are only authorized for patients having allergies or intolerance to the patch adhesive. Zyban (buproprion)	Authorization given for 4-month course of therapy. Four trials of therapy are allowed.
Stadol (butorphanol) PA required for quantities greater than 3 - 2.5 ml metered dose spray pumps within a one-month period	Indicated for management of pain including post-operative analgesia or acute migraine headache pain for patients who meet the following criteria: • No history of hypersensitivity to butorphanol or any components of the product • No history of narcotic dependency or abuse • Not pregnant • No ulcerations of the nasal mucosa • No history of psychological or neurological disorder • No history of head trauma within the previous 7 days • 18 years of age or older • Non-responsive to NSAIDS, acetaminophen, combination analgesics (isometheptene, butalbital, +/- metoclopramide), or ergot derivatives, or these medications are contraindicated.

PA Criteria for Medicaid Prescription Drugs (continued)

Drug	Criteria
Thalomid (thalomide)	Treatment of the cutaneous manifestations of moderate-to-severe erythema nodosum leprosum (ENL). Considered for other diagnoses on individual basis.
Toradol (ketorolac) For quantity greater than a 5-day supply within a month	Indicated for the short-term treatment of acute pain. Authorization considered on an individual basis.
Tretinoin PA required for patients 26 years and older.	Diagnose of: • Skin cancer • Lamellar ichthyosis • Darier-White disease • Psoriasis • Severe recalcitrant (nodulocystic) acne
Xanax XR (alprazolam extended-release tables)	• Xanax XR tables may be covered for patients who have not responded to adequate trials of at least two generic long-acting benzodiazepines, one of which is generic alprazolam. • Coverage of Xanax XR will be allowed for once daily dosing only.
Zoloft 25 mg & 50 mg (sertraline)	Authorized for patients requiring dosages where tab splitting would be inappropriate (i.e., 75 mg, 125 mg).
Zyvox (linezolid)	Adult patients with vancomycin-resistant enterococcus.

PA Criteria for MHSP Prescription Drugs (continued)

Drug	Criteria
buspirone (Buspar)	• Augumentation of depression and/or obsessive compulsive disorder (OCD). • Generalized anxiety disorder.
zaleplon (Sonata) zolpidem (Ambien)	Trial and failure with at least **two** multi-source prescription sleep-inducing drugs.
amotrigine (Lamictal)	• Diagnosis of bi-polar disorder.
guanfacine (Tenex) isradipine (DynaCirc) levothyroxine sodium (Synthroid) liothyronine sodium (Cytomel) pindolol (Visken) propranolol HCl (Inderal) verapamil, verapamil HCl (Calan)	Use as augmentation strategy specifically related to mental health treatment.
maprotiline HCl (Ludiomil)	Considered on an individual basis.
sertraline (Zoloft 25 mg & 50 mg)	Authorized for patients requiring dosages where tablet splitting would be inappropriate (i.e., 75 mg, 125 mg).
gabapentin (Neurontin)	Must specify if anxiety (generalized anxiety, panic disorder, post traumatic stress disorder) and/or compelling reason with bipolar disorder.
topiramate (Topamax)	Diagnosis of bipolar disorder, obesity, intolerance, time effective of Lithium, Depakote, Trileptal/Tegretol.
Antipsychotics Zyprexa Zydis (olanzapine) Risperdal M-tabs (risperidone)	Patients who have special requirements for administration of atypical antipsychotics may be granted prior authorization for these two formulations of Zyprexa and Risperdal.
Risperdal Consta (risperidone)	Prior authorization for Risperdal Consta, a long acting injectable form of Risperdal, requires that the patient must have tried and failed the oral Risperdal or have documented compliance issues.

Other Programs

Clients who are enrolled in the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP) are not enrolled in PASSPORT, so the PASSPORT requirements in this chapter do not apply. However, prior authorization may be required for certain services. Refer to the *Mental Health Services Plan* manual.

For a CHIP medical manual, contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. The CHIP Dental manual and additional CHIP information are available on the *Provider Information* web site (see *Key Contacts*).

MONTANA
Department of Public Health & Human Services

Coordination of Benefits

When Clients Have Other Coverage

Medicaid clients often have coverage though Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* later in this chapter). Medicare coverage is processed differently than other sources of coverage.

Identifying Other Sources of Coverage

The client's Medicaid eligibility information may list other payers such as Medicare or other third party payers (see *Client Eligibility and Responsibilities* in the *General Information For Providers* manual). If a client has Medicare, the Medicare ID number is listed on the eligibility verification. If a client has other coverage (excluding Medicare), it will be shown also. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' compensation insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long term care insurance

*These third party payers (and others) may **not** be listed on the client's eligibility information.

Providers must use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Client Has Medicare

Medicare claims are processed and paid differently than claims involving other payers. The other sources of coverage are referred to as "third party liability" (TPL), but Medicare is not.

Medicare Part A claims

Medicare Part A covers inpatient hospital care, skilled nursing care and other services. Medicaid has not made arrangements with Medicare Part A carriers for electronic exchange of claims covering Part A services. Providers must submit the claim first to Medicare. After Medicare processes the claim, an Explanation of Medicare Benefits (EOMB) is sent to the provider. The provider then reviews the EOMB, and submits the claim to Medicaid. Medicare Part A services are covered in more detail in specific program manuals where the providers bill for Part A services.

Medicare Part B crossover claims

Medicare Part B covers outpatient hospital care, physician care and other services. Although outpatient hospital care is covered under Part B, it is processed by Medicare Part A. The Department has an agreement with Medicare Part B carriers for Montana (BlueCross BlueShield of Montana and the Durable Medical Equipment Regional Carrier [DMERC]). Under this agreement, the carriers provide the Department with a magnetic tape of claims for clients who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically and must have their Medicare provider number on file with Medicaid.

To avoid confusion and paperwork, submit Medicare Part B crossover claims to Medicaid only when necessary.

In these situations, providers need not submit Medicare Part B crossover claims to Medicaid. Medicare will process the claim, submit it to Medicaid, and send the provider an Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see *Billing Procedures*).

When Medicare pays or denies a service

- When Medicare automatic crossover claims are paid or denied, they should automatically cross over to Medicaid for processing, so the provider does not need to submit the claim to Medicaid.
- When Medicare crossover claims are billed on paper and are paid or denied, the provider must submit the claim to Medicaid with the Medicare EOMB (and the explanation of denial codes).

When submitting electronic claims with paper attachments, see the *Billing Electronically with Paper Attachments* section of the *Billing Procedures* chapter in this manual.

When Medicaid does not respond to crossover claims

When Medicaid does not respond within 45 days of the provider receiving the Medicare EOMB, submit a claim and a copy of the Medicare EOMB to Medicaid for processing.

Submitting Medicare claims to Medicaid

When submitting a claim to Medicaid, include the Medicare EOMB and use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the Medicaid provider number and Medicaid client ID number.

Remember to submit Medicare crossover claims to Medicaid only:

- When the referral to Medicaid statement is missing from the provider's EOMB.
- When the provider does not hear from Medicaid within 45 days of receiving the Medicare EOMB.
- When Medicare denies the claim.

When a Client Has TPL (ARM 37.85.407)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability (or TPL). In most cases, the providers must bill other insurance carriers before billing Medicaid.

Providers are required to notify their clients that any funds the client receives from third party payers (when the services were billed to Medicaid) must be turned over to the Department. The following words printed on the client's statement will fulfill this requirement: "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first.

- When a Medicaid client is also covered by Indian Health Service (IHS) or the Montana Crime Victim's Compensation Fund, providers must bill Medicaid before IHS or Crime Victim's. These are not considered third party liability.
- When a client has Medicaid eligibility and Mental Health Services Plan (MHSP) eligibility for the same month, Medicaid must be billed before MHSP.
- Some prenatal and pediatric diagnosis codes can be billed to Medicaid first (see following table). In these cases, Medicaid will "pay and chase" or recover payment itself from the third party payer.

Diagnosis Codes That May be Billed to Medicaid First	
ICD-9-CM Prenatal Codes	**ICD-9-CM Preventive Pediatric Codes**
V22.0	V01.0 – V01.9
V22.1	V02.0 – V02.9
V23.0 – V23.9	V03.0 – V06.9
V28.0 – V28.9	V07.0 – V07.9
640.0 – 648.9*	V20.0 – V20.2
651.0 – 658.9*	V70.0
671.0 – 671.9	V72.0 – V72.3
673.0 – 673.8	V73.0 – V75.9
675.0 – 676.9	V77.0 – V77.7
	V78.1 – V78.3
	V79.2 – V79.3
	V79.8
	V82.3 – V82.4
* In these two ranges, the code only qualifies for the exemption if the fifth digit is a 3 (e.g. 670.13 or 648.93).	

- The following services may also be billed to Medicaid first:
  - Nursing facility (as billed on nursing home claims)
  - Audiology
  - Hearing aids and batteries
  - Drugs (as billed on drug claims)
  - Personal assistance
  - Transportation (other than ambulance)
  - Optometry
  - Oxygen in a nursing facility
  - Dental (as billed on dental claim)
  - Home and community based services (waiver)
- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim. Instead, notify the Department of the potential third party by sending the claim and notification directly to the Third Party Liability Unit (see *Key Contacts*).

Requesting an exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent directly to the ACS Third Party Liability Unit (see *Key Contacts*).

- When a provider is unable to obtain a valid *assignment of benefits* (see *Definitions*), the provider must submit the claim with documentation that the provider attempted to obtain assignment and certification that the attempt was unsuccessful.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
    1. The third party carrier has been billed, and 30 days or more have passed since the date of service.
    2. The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.
- If another insurance has been billed, and 90 days have passed with no response, attach a note to the claim explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation directly to Medicaid in order to avoid missing the timely filing deadline.

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

For details on how Medicaid calculates payment for TPL claims, see the *How Payment Is Calculated* chapter in this manual.

When the third party pays or denies a service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid in the "amount paid" field of the claim when submitting to Medicaid for processing. These claims may be submitted either electronically or on paper.
- Allows the claim, and the allowed amount went toward client's deductible, include the insurance Explanation of Benefits (EOB) when billing Medicaid.
- Denies the claim, include a copy of the denial (including the reason explanation) with the claim, and submit to Medicaid.
- Denies a line on the claim, bill the denied lines together on a separate claim and submit to Medicaid. Include the explanation of benefits (EOB) from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

When submitting electronic claims with paper attachments, see the *Billing Electronically with Paper Attachments* section of the *Billing Procedures* chapter in this manual.

When the third party does not respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Attach to the claim a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company).
- Include the date the claim was submitted to the insurance company.
- Send this information to the ACS Third Party Liability Unit (see *Key Contacts*).

Other Programs

The information covered in this chapter also applies to clients enrolled in the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP) dental and vision providers only.

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Billing Procedures

Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically on a Professional claim or on a CMS-1500 paper claim form (formerly known as the HCFA-1500). CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within the latest of:

- Twelve months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- For claims involving Medicare or TPL, if the twelve month time limit has passed, providers must submit clean claims to Medicaid within:
  - ***Medicare Crossover Claims:*** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
  - ***Claims involving other third party payers (excluding Medicare):*** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All problems with claims must be resolved within this 12 month period.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual).
- If a claim submitted to Medicaid does not appear on the remittance advice within 30 days, contact Provider Relations for claim status (see *Key Contacts*).
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid (see the *Coordination of Benefits* chapter in this manual for more information).

- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the *Coordination of Benefits* chapter in this manual.

When To Bill Medicaid Clients (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid. The main exception is that providers may collect cost sharing from clients.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled client who was accepted as a Medicaid client by the provider, even if the claim was denied.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third-party payer does not respond.
- When a client fails to arrive for a scheduled appointment. Medicaid may not be billed for no-show appointments either.
- When services are free to the client, such as in a public health clinic. Medicaid may not be billed for those services either.

Under certain circumstances, providers may need a signed agreement in order to bill a Medicaid client (see the following table).

If a provider bills Medicaid and the claim is denied because the client is not eligible, the provider may bill the client directly.

When to Bill a Medicaid Client (ARM 37.85.406)

	• Client Is Medicaid Enrolled • Provider Accepts Client as a Medicaid Client	• Client Is Medicaid Enrolled • Provider Does Not Accept Client as a Medicaid Client	• Client Is Not Medicaid Enrolled
Service is covered by Medicaid	Provider can bill client **only** for cost sharing	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client
Service is not covered by Medicaid	Provider can bill client only if custom agreement has been made between client and provider before providing the service	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client

Routine Agreement: This may be a routine agreement between the provider and client which states that the client is not accepted as a Medicaid client, and the he or she must pay for the services received.

Custom Agreement: This agreement lists the service the client is receiving and states that the service is not covered by Medicaid and that the client will pay for it.

Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Cost sharing fees are a set dollar amount per visit, and they are based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. There is no cost sharing cap. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice. Cost sharing for the following services is shown below.

Cost Sharing	
Provider Type	**Amount**
Independent diagnostic testing facility (IDTF)	$4.00 per visit
Mid-level practitioner	$4.00 per visit
Physician	$4.00 per visit
Podiatry	$4.00 per visit
Public Health Clinic	$1.00 per visit

The following clients are exempt from cost sharing:

- Clients under 21 years of age
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed)
- Inpatients in a hospital, skilled nursing facility, intermediate care facility or other medical institution if the individual is required to spend all but their personal needs allowance on the cost of care.
- Medicaid clients who also have Medicare or another insurance are exempt from cost sharing only when the service is allowed by Medicare or paid by the other insurance, and Medicaid is the secondary payer.

Cost sharing may not be charged for the following services:

- Emergencies (see *Definitions*)
- Family planning
- Hospice
- Independent lab and x-ray services
- Personal assistance services
- Home dialysis attendant services
- Home and community based waiver services
- Non-emergency medical transportation services
- Eyeglasses purchased by the Medicaid program under a volume purchasing arrangement
- Well Child EPSDT services

A provider cannot deny services to a Medicaid client because the client cannot pay cost sharing fees at the time services are rendered. However, the client's inability to pay cost sharing fees when services are rendered does not lessen the client's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid clients, that same policy may be used for Medicaid clients. A provider may sever the relationship with a client who has unpaid cost sharing obligation, as long as a consistent policy is followed with Medicaid and non-Medicaid clients. Once the relationship is severed, with prior notice to the client either verbally or in writing, the provider may refuse to serve the client.

When Clients Have Other Insurance

If a Medicaid client is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the client's health care, see the *Coordination of Benefits* chapter in this manual.

PASSPORT Billing Tips

- Do not bill for case management fees; they are paid automatically to the provider each month.
- If you are not your client's PASSPORT provider, include the PASSPORT provider's PASSPORT number on the claim.
- For claims questions, contact Provider Relations (see *Key Contacts*).

Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (Eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the service(s) before billing Medicaid for the service(s).

For more information on retroactive eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Place of Service

Place of service must be entered correctly on each line. Medicaid typically reduces payment for services provided in hospitals and ambulatory surgical centers since these facilities typically bill Medicaid separately for facility charges.

Physician clinics that are affiliated with hospitals should be particularly careful. If the Department has granted a clinic "provider-based" status then the hospital can bill for facility charges even if the clinic is not on the hospital campus. In these situations the clinic must show "outpatient" (22) as the place of service.

Multiple Visits (E&M Codes) on Same Date

Medicaid generally covers only one visit (or hospital admission) per client per day. When a client requires additional visits on the same day, use a modifier to describe the reason for multiple visits. When a modifier is not appropriate for the situation, attach documentation of medical necessity to the claim, and submit it to the appropriate Department program officer (see *Key Contacts* or the *Program Policy Information* table in the *General Information For Providers manual*).

Coding

Always refer to the long descriptions in coding books.

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the table of *Coding Resources* on the following page. The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT-4, HCPCS Level II, and ICD-9-CM coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use specific codes rather than miscellaneous codes. For example, 99213 is more specific (problem-focused visit) than 99499 (unlisted evaluation and management service).
- Follow CPT-4 guidelines on the difference between a new patient and an established patient.
- Bill for the appropriate level of service provided. For example, the CPT-4 coding book contains detailed descriptions and examples of what differentiates a level 1 office visit (99201) from a level 5 office visit (99205).
- Services covered within "global periods" for certain CPT-4 procedures are not paid separately and must not be billed separately. Most surgical and obstetric procedures and some medical procedures include routine care before and after the procedure. Medicaid fee schedules show the global period for each CPT-4 service.
- Use the correct "units" measurement on claims. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II billing manuals. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be 15 minutes, a percentage of body surface area, or another quantity. Always check the long text of the code description.
- CPT codes that are billed based on the amount of time spent with the client must be billed with the code that is closest to the time spent. For example, a provider spends 60 minutes with the client. The code choices are 45 to 50 minutes or 76 to 80 minutes. The provider must bill the code for 45 to 50 minutes.

Coding Resources

Please note that the Department does not endorse the products of any particular publisher.

Resource	Description	Contact
ICD-9-CM	• ICD-9-CM diagnosis and procedure codes definitions • Updated each October.	Available through various publishers and bookstores
CPT-4	• CPT-4 codes and definitions • Updated each January	American Medical Association (800) 621-8335 www.amapress.com or Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
HCPCS Level II	• HCPCS Level II codes and definitions • Updated each January and throughout the year	Available through various publishers and bookstores or from CMS at www.hcfa.gov/medicare/hcpcs.htm
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 www.amapress.com
Miscellaneous resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 www.ntis.gov/product/correct-coding.htm

Using the Medicaid Fee Schedule

When billing Medicaid, it is important to use the Department's fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. In addition to covered services and payment rates, fee schedules often contain helpful information such as appropriate modifiers, global periods, if multiple surgery guidelines apply, if the procedure can be done bilaterally, if an assistant, co-surgeon, or team is allowed for the procedure, if the code is separately billable, and more. Department fee schedules are updated each January and July. Current fee schedules are available on the *Provider Information* web site (see *Key Contacts*). For disk or hardcopy, contact Provider Relations (see *Key Contacts*).

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4, HCPCS Level II, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes only two pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- When billing with modifier 50 for bilateral services, put all information on one line with one unit. For example, a bilateral carpal tunnel surgery would be billed like this:

	24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	08	23	02	08	23	02	22	0	64721	50	1	800 00	1				

- Check the fee schedule to see if Medicaid allows the use of the following modifiers for a particular code: bilateral (50), multiple procedures (51), co-surgery (62), assistant at surgery (80, 81, 82, AS), and team surgery (66).
- Always bill your main surgical procedure code on line 1 of the claim with one unit only. All other subsequent procedures should be billed with the number of units done for each code per line. For instance, if the main procedure code is 11600, one unit, and the subsequent procedure code is 11601, two units, bill as follows:

	24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	03	05	02	03	05	02	11	0	11600		1	115 00	1				
2	03	05	02	03	05	02	11	0	11601	51	1	140 00	2				

Do not separate out subsequent procedure codes (e.g., code 11601 51 twice) on separate lines. This will cause exact duplicate line denials. Subsequent procedure modifiers should be used when appropriate (for example: modifiers 51 or 59), except when billing add-on codes and modifier 51 exempt codes.

Billing Tips for Specific Provider Types

Mid-level practitioner billing

Mid-level practitioners must bill under their own Medicaid ID number rather than under a physician number.

Physician billing

- Medicaid-enrolled providers may bill for locum tenens services using modifier Q6.
- Durable medical equipment (DME) providers must bill prosthetic and orthotic devices under their DME provider number. Physicians may bill

only specific DME supplies and must check the fee schedule for appropriate codes.

Podiatrist billing

Podiatrists must use appropriate codes and modifiers from their specific fee schedule.

Independent diagnostic testing facilities

IDTF providers must use appropriate fee schedules, codes, and modifiers for their provider type.

Independent labs

- The provider's current CLIA certification number must be on file with Provider Relations or all lab claims will be denied. See *Key Contacts* for CLIA certification information.
- This requirement also applies to public health labs. Questions regarding public health labs may be directed to the Public Health Lab Assistance hotline (see *Key Contacts).*

Imaging

- Repeat modifiers should be used to indicate multiple radiology services of the same radiology code performed on the same day for the same client by the same or different providers. Repeat modifiers are specific modifiers used to indicate that a service is a repeat rather than a duplicate. Examples are modifers -76 and -77.
- For multiple radiology services of the same code provided by the **same** provider on the same date of service, bill the first unit as one unit on one line, followed by additional units of the same code on an additional line with a -76 modifier. See the example below.

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03	05	02	03	05	02	11	0	71010		1	34 00	1				
2 03	05	02	03	05	02	11	0	71010	76	1	34 00	2				

- For radiology services of the same code provided by a **different** provider on the same date of service as another provider, bill all units on one line with a -77 modifier. See the example below.

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03	05	02	03	05	02	11	0	71010	77	1	34 00	2				

- If a claim is denied as a duplicate, send copies of the radiology report, the denial statement, and the claim to the appropriate Department program officer (see *Key Contacts, Lab and X-ray*) for review.

- For bilateral x-rays, bill on separate lines, one line with modifier RT and one line with modifier LT. The exception would be codes that are described as bilateral in their code description. These are to be billed on one line with one unit.
- Imaging providers must take particular care in the use of modifiers. The TC modifier is used when only the technical portion of the service is provided. The provider who interprets the results uses modifier 26. When both technical and professional services are performed by the same provider, no modifier is required.

Billing Tips for Specific Services

Abortions

A completed *Medicaid Recipient/Physician Abortion Certification* (MA-37) form must be attached to every abortion claim or payment will be denied (see *Appendix A: Forms*). Complete only one part (I, II, or III) of this form; the part used must be clearly indicated on the form. This is the only form Medicaid accepts for abortions.

Anesthesia

- Use appropriate CPT-4 anesthesia codes.
- Do not use surgery codes with an anesthesia modifier.
- For services where codes or definitions differ between the CPT-4 and the *American Society of Anesthesiologists' Relative Value Guide*, Medicaid adopts the CPT-4 version.
- Include the total number of minutes on the claim. Medicaid will convert the number of minutes to the number of time units. Do not include the base units on the claim as the claims processing system determines the number of base units (see the *Completing a Claim* chapter in this manual).

Bundled services

Certain services with CPT-4 codes (eg., telephone advice, some pulse oximetry services) are covered by Medicaid but have a fee of zero. This means that the service is typically "bundled" with an office visit or other service. Since the bundled service is covered by Medicaid, providers may not bill the client separately for it.

Cosmetic services

Include the prior authorization number in on the claim (see the *Completing a Claim* chapter in this manual).

EPSDT Well Child Screens

- Bill for a complete screen using the appropriate evaluation and management (E&M) code for preventive medicine services.
- When billing for partial screens, use the appropriate preventive medicine code with modifier 52 (reduced services).
- See also the Well Child EPSDT chapter in this manual.
- For Well Child EPSDT indicators, see the *Completing a Claim* chapter in this manual.

Family planning services

Contraceptive supplies and reproductive health items provided free to family planning clinics cannot be billed to Medicaid. When these supplies are not free to the clinic, providers associated with a family planning clinic can bill Medicaid for the following items:

Item	Code
Diaphragm	A4266
Male condoms	A4267
Female condoms	A4268
Spermicide	A4269
Oral contraceptives	S4993

For family planning indicators, see the *Completing a Claim* chapter in this manual.

Immunizations

- Use code 90471 or 90465 with modifier SL to bill for the first administration of vaccines under the Vaccines for Children (VFC) program. Use 90472-SL or 90446-SL for subsequent VFC administrations. (For proper code assignment, refer to your CPT code manual for the code description differences for codes 90465 and 90466 versus codes 90471 and 90472.)
- There must be a VFC covered vaccine code for each unit of service billed with code 90471-SL and 90472-SL or 90465-SL and 90466-SL. For a list of VFC covered vaccines, contact the Department's immunization program at (406) 444-5580.
- No more than four diagnosis codes are necessary.
- Bill each VFC vaccine code with $0.00 charges.

For example, a provider administers three vaccines: MMR, pneumococcal conjugate, and DTaP.

	24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	12	12	03	12	12	03	11	0	90471	SL	1	10 00	1				
2	12	12	03	12	12	03	11	0	90472	SL	1	20 00	2				
3	12	12	03	12	12	03	11	0	90707		1	0 00	1				
4	12	12	03	12	12	03	11	0	90669		1	0 00	1				
5	12	12	03	12	12	03	11	0	90700		1	0 00	1				

Obstetrical services

If the provider's care includes prenatal (antepartum) and/or postnatal (postpartum) care in addition to the delivery, the appropriate global OB code must be billed. Antepartum care includes all visits until delivery, and there are different codes for specified numbers of visits. There are also different codes for antepartum and postpartum care when only one or the other is provided. Please review your CPT coding book carefully.

Reference lab billing

Under federal regulations, all lab services must be billed to Medicaid by the lab that performed the service. Modifier 90, used to indicate reference lab services, is not covered by Medicaid.

Sterilization

- For elective sterilizations, a completed *Informed Consent to Sterilization* (MA-38) form must be attached to the claim for each provider involved or payment will be denied. This form must be legible, complete, and accurate, and revisions are not accepted. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.
- For medically necessary sterilizations (including hysterectomies, oophorectomies, salpingectomies, and orchiectomies), one of the following must be attached to the claim, or payment will be denied:
    - A completed *Medicaid Hysterectomy Acknowledgement* form (MA- 39) for each provider submitting a claim. See *Appendix A Forms*. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (section B) or life-threatening emergency (section C) exists, the client (or representative, if any) and physician must sign and date Section A of this form prior to the procedure (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). Also, for section A, signatures dated after the surgery date

require manual review of medical records by the Department. The Department must verify that the client (and representative, if any) was informed orally and in writing, prior to the surgery, that the procedure would render the client permanently incapable of reproducing. The client does not need to sign this form when sections B or C are used. Please refer to *Appendix A* for more detailed instructions on completing the form.

- For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
    - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
    - The reason for the hysterectomy was a life-threatening emergency.
    - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (Eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. For more information on sterilizations, see the *Covered Services* chapter in this manual.

Surgical services

- Medicaid does not provide additional payment for the “operating room” in a physician's office. Medicaid pays facility expenses only to licensed hospitals and ambulatory surgical centers.
- ***Reporting surgical services:*** Certain surgical procedures must not be reported together, such as:
    - Procedures that are mutually exclusive based on the CPT-4 code description or standard medical practice.
    - When both comprehensive and component procedures are performed, only the comprehensive procedure must be billed.
    - When the CPT-4 manual describes several procedures of increasing complexity, only the code describing the most extensive procedure performed must be reported.

Medicaid edits for some surgical services using Medicare’s Correct Coding Initiative (CCI) edits and performs post-payment review on others. See *Coding Resources* earlier in this chapter for more information on CCI.

- ***Assistant at surgery***
  - When billing for an assistant at surgery, refer to the current Medicaid Department fee schedule to see if an assist is allowed for that procedure.
  - If an assistant at surgery does not use the appropriate modifier, then either the assistant's claim or the surgeon's claim (whichever is received later) will be denied as a duplicate service.
  - Physicians must bill assistant at surgery services using the appropriate surgical procedure code and modifier 80, 81, or 82.
  - Mid-level practitioners must bill assistant at surgery services under their own provider number using the appropriate surgical procedure code and modifier AS, 80, 81, or 82.
- ***Global surgery periods:*** Global surgery periods are time spans assigned to surgery codes. During these time spans, services related to the surgery may **not** be billed. Group practice members that are of the same specialty must bill Medicaid as if a single practitioner provided all related follow-up services for a client. For example, Dr. Armstrong performs orthopedic surgery on a client. The client comes in for a follow-up exam, and Dr. Armstrong is on vacation. Dr. Armstrong's partner, Dr. Black, performs the follow-up. Dr. Black cannot bill this service to Medicaid, because the service was covered in the global period when Dr. Armstrong billed for the surgery.
  - For major surgeries, this span is 90 days and includes the day prior to the surgery and the following services: post-operative surgery related care and pain management and surgically-related supplies and miscellaneous services.
  - For minor surgeries and endoscopies, the spans are either one day or ten days. They include any surgically-related follow-up care and supplies on the day of surgery, and for a 10-day period after the surgery.
  - For a list of global surgery periods by procedure code, please see the current Department fee schedule for your provider type.
  - If the CPT-4 manual lists a procedure as including the surgical procedure only (i.e., a "starred" procedure) but Medicaid lists the code with a global period, the Medicaid global period applies. Almost all Medicaid fees are based on Medicare relative value units (RVUs), and the Medicare relative value units were set using global periods even for starred procedures. Montana Medicaid has accepted these RVUs as the basis for its fee schedule.
  - In some cases, a physician (or the physician's partner of the same specialty in the same group practice) provides care within a global period that is unrelated to the surgical procedure. In these circumstances, the

unrelated service must be billed with the appropriate modifier to indicate it was not related to the surgery.

Telemedicine services

- When performing a telemedicine consult, use the appropriate CPT-4 evaluation and management (E&M) consult code.
- The place of service is the location of the provider providing the telemedicine service.
- Medicaid does not pay for network use or other infrastructure charges.

Transplants

Include the prior authorization number on the claim (field 23 on the CMS-1500 claim form). See the *Completing a Claim* chapter in this manual. All providers must have their own prior authorization number for the services. For details on obtaining prior authorization, see the *PASSPORT and Prior Authorization* chapter in this manual.

Weight reduction

Providers who counsel and monitor clients on weight reduction programs must bill Medicaid using appropriate evaluation and management (E&M) codes.

Submitting Electronic Claims

Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS

EDI Gateway. For more information on using the ACS clearinghouse, contact ACS EDI Gateway (see *Key Contacts*).

- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

Billing Electronically with Paper Attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

9999999 -	**888888888** -	**11182003**
Medicaid Provider ID	Client ID Number	Date of Service (mmddyyyy)

The supporting documentation must be submitted with a paperwork attachment coversheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Submitting Paper Claims

For instructions on completing a paper claim, see the *Completing a Claim* chapter in this manual. Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Claim Inquiries

Contact Provider Relations for questions regarding client eligibility, payments, denials, general claim questions, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A.* Complete the top portion of the form with the provider's name and address. If you are including a copy of the claim, complete side A; if a copy of the claim is not included, complete side B.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client: • View the client's eligibility information at each visit. Medicaid eligibility may change monthly. • Verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Duplicate claim	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim (see *Remittance Advices and Adjustments* in this manual). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim when such approval is required. See the *PASSPORT and Prior Authorization* chapter in this manual.
Prior authorization number is missing	• Prior authorization (PA) is required for certain services, and the PA number must be on the claim (see the *PASSPORT and Prior Authorization* chapter in this manual). • Mental Health Services Plan (MHSP) claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization. See the *Mental Health Services Plan* manual.
TPL on file and no credit amount on claim	• If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See *Coordination of Benefits* in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim.
Claim past 365-day filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*.
Missing Medicare EOMB	All Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) included.
Provider is not eligible during dates of services, or provider number terminated	• Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Type of service/procedure is not allowed for provider type	• Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

These billing procedures also apply to the Mental Health Services Plan (MHSP). These billing procedures do not apply to the Children's Health Insurance Plan (CHIP). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

MONTANA
Department of Public Health & Human Services

Completing a Claim Form

The services described in this manual are billed either electronically on a Professional claim or on a CMS-1500 paper claim form. Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the *Billing Procedure*s chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Client has Medicaid coverage only
- Client has Medicaid and Medicare coverage
- Client has Medicaid and third party liability coverage
- Client has Medicaid, Medicare, and third party liability coverage
- Client has Medicaid, Medicare, and Medicare supplement coverage

When completing a claim, remember the following:

- Required fields are indicated by "*".
- Fields that are required if the information is applicable to the situation or client are indicated by "**".
- Field 24h, *EPSDT/family planning*, is used as an indicator to specify additional details for certain clients or services. The following are accepted codes:

EPSDT/Family Planning Indicators

Code	Client/Service	Purpose
1	EPSDT	This indicator is used when the client is under age 21
2	Family planning	This indicator is used when providing family planning services.
3	EPSDT and family planning	This indicator is used when the client is under age 21 and is receiving family planning services
4	Pregnancy (any service provided to a pregnant woman)	This indicator is used when providing services to pregnant women
6	Nursing facility client	This indicator is used when providing services to nursing facility residents

- Unless otherwise stated, all paper claims must be mailed to the following address:

Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

Client Has Medicaid Coverage Only

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a	Insured's ID number	Leave this field blank for Medicaid only claims.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
5	Patient's address	Client's address.
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11d*	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format. This field is optional for Medicaid only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format. This field is optional for Medicaid only claims.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix C*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT-4/HCPCS modifier. Medicaid allows up to three modifiers per procedure code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i	EMG (Emergency)	Not used.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter $0.00. Do not report any client copay or Medicaid payment amounts on this form.
30	Balance due	Enter the balance due as recorded in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid Coverage Only

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Chuckie L.

3. PATIENT'S BIRTH DATE: MM 04 DD 28 YY 96 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Anystreet #1

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-5555

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM 09 DD 10 YY 00 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Doug Ross, MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 9989999

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 381.20
2. 474.12
3. 474.01
4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 18 02		24	0	69436	50	1	500 00	1				
2 03 18 02		24	0	42830	51	2,3	450 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 99999

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 950 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 950 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Doug Ross, MD 03/20/02

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Anytown Surgicenter
123 Medical Drive
Anytown, MT 59999

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

The Pediatric Center
P.O. Box 999
Anytown, MT 59999

PIN# 0000099999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid and Medicare Coverage

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11	Insured's policy group	This field should be blank.
11c	Insurance plan or program	This field should be blank.
11d*	Is there another health benefit plan?	Check "NO".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix C*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i	EMG (Emergency)	Not used.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave this field blank. Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30	Balance due	Enter the balance due as listed in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid and Medicare Coverage

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
( ) (Medicare #) (X) (Medicaid #) ( ) (Sponsor's SSN) ( ) (VA File #) ( ) (SSN or ID) ( ) (SSN) ( ) (ID)	999999999A
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jones, Jerry	3. PATIENT'S BIRTH DATE MM DD YY: 02 04 33; SEX: M (X) F ( )
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same	
5. PATIENT'S ADDRESS (No., Street): 4321 Anystreet	6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other ( )
7. INSURED'S ADDRESS (No., Street): Same	
CITY: Anytown; STATE: MT	8. PATIENT STATUS: Single (X) Married ( ) Other ( )
CITY; STATE	
ZIP CODE: 59999; TELEPHONE (Include Area Code): (406) 555-9999	Employed (X) Full-Time Student ( ) Part-Time Student ( )
ZIP CODE; TELEPHONE (INCLUDE AREA CODE): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ( ) NO (X)
a. INSURED'S DATE OF BIRTH MM DD YY; SEX M ( ) F ( )	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M ( ) F ( )	b. AUTO ACCIDENT? YES ( ) NO (X) PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ( ) NO (X)
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE: 999999999
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO (X) *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Carter, Edward MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN: 9999999	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM: 12 07 01 TO: 12 24 01
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ( ) NO (X) $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 486 . 2. . 3. . 4. .		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 07 01	12 07 01	21	0	99223		1	200 00	1				
2 12 08 01	12 08 01	21	0	99223		1	75 00	1				
3 12 09 01	12 09 01	21	0	99223		1	75 00	1				
4 12 10 01	12 10 01	21	0	99223		1	75 00	1				
5 12 13 01	12 13 01	21	0	99223		1	75 00	1				
6 12 15 01	12 15 01	21	0	99223		1	75 00	1				

25. FEDERAL TAX I.D. NUMBER / SSN / EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
99-9999999 ( ) (X)	99999999ABC	(X) YES ( ) NO	$ 575 00	$	$ 575 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Edward Carter, MD 06/15/02 SIGNED DATE	Anytown Hospital 12345 Medical Drive Anytown, MT 59999	Family Healthcare 321 Medical Drive Anytown, MT 59999 PIN# 9999999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid and Third Party Liability Coverage

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's ID number for the primary carrier.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11	Insured's policy group	Leave this field blank, or enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix C*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures, Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i	EMG (Emergency)	Not used.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the other insurance. Do not include any adjustment amounts or coinsurance.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid and Third Party Liability Coverage

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

For Medicaid use. Do not write in this area.

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jackson, Renee P.

3. PATIENT'S BIRTH DATE MM DD YY: 08 31 80 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 4321 Anystreet

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406)999-9999

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 999999999B

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 9999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY 01 16 02 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Smith, Steven R. MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 9999999

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 845.02 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 16 02	01 16 02	11	0	99203		1	75 00	1				
2 01 16 02	01 16 02	11	0	73610		1	45 00	1				
3 01 16 02	01 16 02	11	0	L1930		1	125 00	1				
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 245 00

29. AMOUNT PAID $ 129 00

30. BALANCE DUE $ 116 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

John Pied, DPM 01/16/02

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

The Foot Group
25 Medical Drive
Anytown, MT 59999

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

The Foot Group
P.O. Box 999
Anytown, MT 59999

PIN# 999999 GRP# (406) 999-9999

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid, Medicare, and Third Party Liability Coverage

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11*	Insured's policy group	Enter the client's primary payer (TPL) ID number.
11c*	Insurance plan or program	Enter the name of the primary payer.
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix C*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i	EMG (Emergency)	Not used.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the primary payer (not Medicare). Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid, Medicare, and Third Party Liability Coverage

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Olsen, Karen Z.

3. PATIENT'S BIRTH DATE MM DD YY: 11 07 62 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 98765 Anystreet #2

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 999-9999

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 999999999A

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY: 06 23 02 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:

17a. I.D. NUMBER OF REFERRING PHYSICIAN:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE:

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 690.10
2. 078.10
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 20 01	12 20 01	11	0	17110		1,2	79 20	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 99-9999999 [X]

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 79 20

29. AMOUNT PAID: $ 32 00

30. BALANCE DUE: $ 47 20

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Steven Sloan, MD 01/31/02

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Steven Sloan, MD
P.O. Box 999
Anytown, MT 59999

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Steven Sloan, MD
P.O. Box 999
Anytown, MT 59999

PIN# 999999 GRP# (406) 999-9999

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11*	Insured's policy group	Enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix C*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	If applicable, enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	Enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i	EMG (Emergency)	Not used.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the Medicare supplement insurance only. Do not include any adjustment amounts or coinsurance. Medicare payment is determined from the EOMB attached to the claim.
30*	Balance due	Enter balance due (amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, George P.

3. PATIENT'S BIRTH DATE: 05 13 35 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 123 Sun City Road

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-5555

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 999999999B

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Supplemental Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 599.0 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 05 07 02	05 07 02	11	0	99212		1	50 00	1				
2 05 07 02	05 07 02	11	0	81002		1	7 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 57 00

29. AMOUNT PAID: $ 12 00

30. BALANCE DUE: $ 45 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Steven Sloan, MD 01/31/02

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Steven Sloan, MD
P.O. Box 999
Anytown, MT 59999

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Steven Sloan, MD
P.O. Box 999
Anytown, MT 59999

PIN# 999999 GRP# (406) 999-9999

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

CMS-1500 Agreement

Your signature on the CMS-1500 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Avoiding Claim Errors

Claims are often denied or even returned to the provider before they can be processed. To avoid denials and returns, double check each claim to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

Common Claim Errors

Claim Error	Prevention
Required field is blank	Check the claim instructions earlier in this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required field (field 10d); verify that the client's Medicaid ID number is listed as it appears on the client's eligibility information.
Client name missing	This is a required field (field 2); check that it is correct.
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Referring or PASSPORT provider name and ID number missing	When a provider refers a client to another provider, include the referring provider's name and ID number or PASSPORT number (see *PASSPORT and Prior Authorization* in this manual).
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim in field 23 (see *PASSPORT and Prior Authorization* in this manual).
Not enough information regarding other coverage	Fields 1a and 11d are required fields when a client has other coverage (refer to the examples earlier in this chapter).
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a CMS-1500 claim form (or an electronic professional claim).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Medicare EOMB not attached	When Medicare is involved in payment on a claim, the Medicare EOMB must be attached to the claim or it will be denied.

Other Programs

This chapter also applies to claims forms completed for MHSP services and CHIP eyeglass services.

MONTANA
Department of Public Health & Human Services

Remittance Advices and Adjustments

The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Electronic RA

Providers may receive the RA electronically as an ANSI ASC X12N 835 transaction, or through the Internet on the Montana Eligibility and Payment System (MEPS). For more information on X12N 835 transactions, see the Companion Guides available on the ACS EDI Gateway website and the Implementation Guides on the Washington Publishing Company website (see *Key Contacts*).

Electronic RAs are available for only six weeks on MEPS.

MEPS is available through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form;* see *Payment and the RA* within this chapter). After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

If a claim was denied, please read the reason and remark code description before taking any action on the claim.

RAs are available from MEPS in PDF and a flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the "SOR Download" page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks. For more information on MEPS, see *Payment and the RA* later in this chapter.

Paper RA

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.

The pending claims section of the RA is informational only. Please do not take any action on claims displayed here.

Sections of the Paper RA

Section	Description
RA notice	The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.
Paid claims	This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter).
Denied claims	This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter.
Pending claims	All claims that have not reached final disposition will appear in this area of the paper RA (pended claims are not available on X12N 835 transactions). The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied. Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.
Credit balance claims	Credit balance claims are shown here until the credit has been satisfied.
Gross adjustments	Any gross adjustments performed during the previous cycle are shown here.
Reason and remark code description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

(1)

JOHN R. SMITH MD
2100 NORTH MAIN STREET
WESTERN CITY MT 59988

(2) PROVIDER# 0001234567 (3) REMIT ADVICE #123456 (4) WARRANT # 654321 (5) DATE:02/15/04 PAGE 2 (6)

RECIP ID (7)	NAME (8)	SERVICE DATES FROM	TO (10)	UNIT OF SVC (11)	PROCEDURE REVENUE NDC (12)	TOTAL CHARGES (13)	ALLOWED (14)	CO-PAY (15)	REASON/ REMARK CODES (16)
PAID CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	010304	010304	1	99212	35.00	29.20	Y	
(9) ICN	00404011250000700								
		LESS MEDICARE PAID*******					26.25		
		LESS COPAY DEDUCTION**					1.46	(17)	
		CLAIM TOTAL*******				35.00	1.49		
DENIED CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	020104	020104	1	99213	45.00	0.00	N	
ICN	00404011250000800								
		020304	020304	1	99214	60.00	0.00	(17) N	
		CLAIM TOTAL*******				105.00			31MA61
PENDING CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	020404	020404	1	99213	45.00	0.00	(17) N	133
ICN	00404011250000900	020504	020504	1	99214	60.00	0.00	N	133
		CLAIM TOTAL*******				105.00			

**********THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE**********

31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.

MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Key Fields on the Remittance Advice

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider by Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information: 0 00111 11 123 000123 A B C D E A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or point-of-sale (POS) pharmacy claim) B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)
10. Service dates	Date(s) services were provided. If service(s) were performed in a single day, the same date will appear in both columns
11. Unit of service	The units of service rendered under this procedure or NDC code.
12. Procedure/revenue/NDC	The procedure code (CPT, HCPCS, National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Copay	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
16. Reason/Remark Codes	A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Credit balances

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

1. By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

The credit balance section is informational only. Do not post from credit balance statements.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or requesting Provider Relations to complete a gross adjustment.

Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in *Billing Procedures* chapter).

Rebilling Medicaid

Rebilling is when a provider submits a claim (or claim line) to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* and *Completing a Claim* chapters.

When to rebill Medicaid

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Explanation of Benefits (EOB) code, make the appropriate corrections, and resubmit the claim to Medicaid (not an adjustment).

Rebill denied claims only after appropriate corrections have been made.

- ***Line Denied.*** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. Do not use an adjustment form.
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to rebill

- Check any EOB code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to cross out or omit all lines that have already been paid. The claim must be neat and legible for processing.
- Enter any insurance (TPL) information on the corrected claim, or include insurance denial information with the corrected claim, and submit to Medicaid.

Adjustments

Adjustments can only be made to paid claims.

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see *Billing Procedures, Claim Inquiry*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

When submitting electronic claims with paper attachments, see the *Billing Electronically with Paper Attachments* section of the *Billing Procedures* chapter in this manual.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit will be a 2, indicating an adjustment. See *Key Fields on the Remittance Advice* earlier in this chapter. Adjustments are processed in the same time frame as claims.

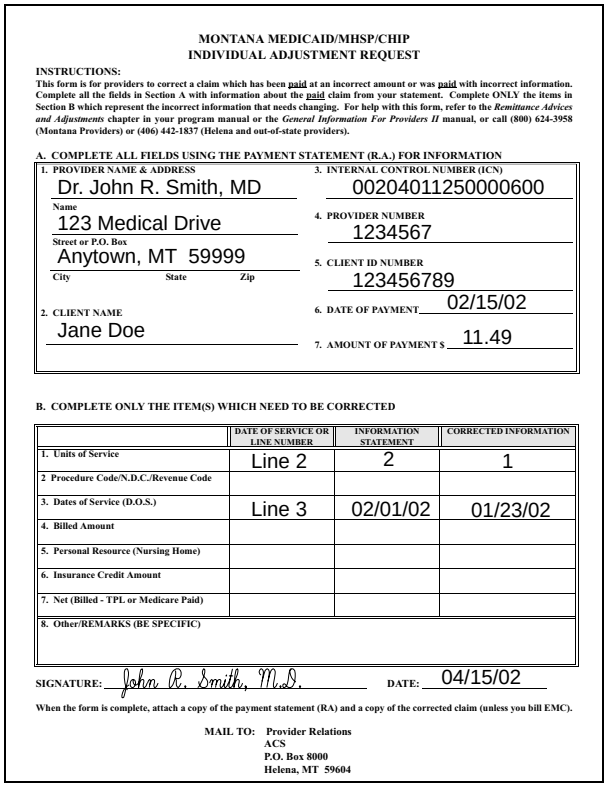
When to request an adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).

How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix A.* The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section of the adjustment form.



MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:
This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS
Dr. John R. Smith, MD
Name
123 Medical Drive
Street or P.O. Box
Anytown, MT 59999
City State Zip

2. CLIENT NAME
Jane Doe

3. INTERNAL CONTROL NUMBER (ICN)
00204011250000600

4. PROVIDER NUMBER
1234567

5. CLIENT ID NUMBER
123456789

6. DATE OF PAYMENT 02/15/02

7. AMOUNT OF PAYMENT $ 11.49

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service	Line 2	2	1
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)	Line 3	02/01/02	01/23/02
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: John R. Smith, M.D. DATE: 04/15/02

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Sample Adjustment Request

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A.* You may also order forms from Provider Relations or download them from the *Provider Information* web site (see *Key Contacts*). Complete Section A first with provider and client information and the claim's ICN number (see following table and sample RA).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
   - Enter the date of service or the line number in the *Date of Service or Line Number* column.
   - Enter the information from the claim that was incorrect in the *Information on Statement* column.
   - Enter the correct information in the column labeled *Corrected Information*.

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Recipient name	The client's name is here.
3.* Internal control number (ICN)	There can be only one ICN per adjustment request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider number	The provider's Medicaid ID number.
5.* Recipient Medicaid number	Client's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice field #5 (see the sample RA earlier in this chapter).
7. Amount of payment	The amount of payment from the remittance advice field #17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/ NDC/ Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (Nursing facility)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

3. Attach copies of the RA and a corrected claim if necessary.
   - If the original claim was billed electronically, a copy of the RA will suffice.
   - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit balance or a check from the provider (see *Credit balances* earlier in this chapter).
- Any questions regarding claims or adjustments must be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments by a Provider Notice or on the first page of the remittance advice (RA Notice section). Mass adjustment claims shown on the RA have an ICN that begins with a "4" (see *Key Fields on the Remittance Advice* earlier in this chapter).

Payment and The RA

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A). One form must be completed for each provider number. See the following table, *Required Forms for EFT and/or Electronic RA.*

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. See *Direct Deposit Arrangements* under *Key Contacts* for questions or changes regarding EFT.

Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

Required Forms For EFT and/or Electronic RA

All three forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form)	• Provider Information website • Provider Relations (see *Key Contacts*)	Provider Relations (see *Key Contacts*)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider Information website (see *Key Contacts*) • Provider's bank	Provider Relations (see *Key Contacts*)
MEPS Access Request Form	Allows provider to receive a password to access their RA on MEPS	• Provider Information website • Virtual Human Services Pavilion • Direct Deposit Arrangements (see *Key Contacts)*	DPHHS address on the form

Other Programs

The information in this chapter also applies to the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP) vision and dental services only.

MONTANA
Department of Public Health & Human Services

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter in order to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

The RBRVS Fee Schedule

Most services by physicians, mid-level practitioners, podiatrists, independent imaging facilities, independent diagnostic testing facilities, and public health clinics are paid for using the Department's RBRVS fee schedule. RBRVS stands for Resource-Based Relative Value Scale. The fee schedule includes about 7,700 CPT-4 codes, about 1,600 HCPCS Level 2 codes. Within the CPT-4 coding structure, only anesthesia services (00100-01999) and clinical lab services (almost the entire 80000-89999 range) are not paid for using the RBRVS fee schedule.

RBRVS was developed for the Medicare program, which first implemented it in 1992. Medicare does a major update annually, with smaller updates performed quarterly. Montana Medicaid implemented its RBRVS-based fee schedule in August 1997. It is based largely on the Medicare model, with a few differences that will be described below. By adapting the Medicare model to the needs of the Montana Medicaid program, the Department was able to take advantage of the millions of dollars of research performed by the federal government and national associations of physicians and other health care professionals. RBRVS-based payment methods are widely used across the U.S. by Medicaid programs, BlueCross BlueShield plans, workers' compensation plans and commercial insurers.

The following paragraphs elaborate on aspects of the RBRVS fee schedule used by the Department. All numerical examples are from July 2002 and may not apply at other times.

Fee calculation

Each fee is the product of a relative value times a conversion factor. For example, the fee for a Level 2 office visit for an established client (99212) is:

0.906 relative value units x conversion factor of $31.90 = $28.90

Many Medicaid payment methods are based on Medicare, but there are differences. In these cases, the Medicaid method prevails.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

When Medicaid payment differs from the fee schedule, consider the following:

- The Department pays the lower of the established Medicaid fee or the provider's charge
- Modifiers (see *Other modifiers* in this chapter)
- Provider type (see *Professional differentials* in this chapter)
- Place of service (see *Site of service differential* in this chapter)
- Date of service (fees for services may change over time)
- Also check for cost sharing and Medicare or TPL payments which will be shown on the RA.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

Basis of relative values

For almost all services, Medicaid uses the same relative values as Medicare does in Montana. (Nationally, Medicare adjusts the relative values for differences in practice costs between localities, but Montana is considered a single locality.) For fewer than 1% of codes, relative values are not available from Medicare. For these codes, the Department has set the relative values.

Composition of relative values

For each code, the relative value is the sum of a relative value for the work effort (including time, stress, and difficulty), the associated practice expense and the associated malpractice expense. For a Level 2 office visit (99212), for example, the composition is as follows:

0.428 work RVUs + 0.464 practice expense RVUS + 0.015 malpractice expense RVUs = 0.906 total RVUs

Site of service differential

The Medicare program has calculated two sets of relative values for each code – one that reflects the practitioner's practice cost of performing the service in an office and one that reflects the practitioner's practice cost of performing the service in a hospital or ambulatory surgical center (ASC). When services are provided within a hospital or ASC (i.e., places of service 21–24), Medicaid typically pays a lower fee than if the service is provided in the office or another setting. The reason is that Medicaid typically also pays the hospital or ASC for the service. For example, in July 2002 Medicaid would pay a physician for a Level 2 office visit (99212) as follows:

In office: 0.906 RVUs x conversion factor of $31.90 = $28.90

In hospital or ASC: 0.591 RVUs x $31.90 = $18.85

Conversion factor

The Department sets the conversion factor for the state fiscal year (July through June). The conversion factor is typically reviewed (and often changed) in July of each year. In July 2002 it was updated to $31.90, compared with the Medicare conversion factor of $36.20.

Transition adjustor

Because the move to an RBRVS-based fee schedule in August 1997 resulted in large changes in fees for some services, the Montana legislature directed the Department to pay transitional fees for about 2,250 of the 9,300 services covered by the fee schedule. For about 900 services, the transitional fee is lower than it otherwise would be; for 1,350 services, it is higher than it otherwise would be. The transitional fees are put in place by a transition adjustor. Here are examples:

Level 3 office visit, established patient (99213)

1.263 RVUs x transition adjustor of 0.82 x conversion factor of $31.90 = $33.04

Create eardrum opening (69436)
3.760 RVUs x transition adjustor of 1.36 x conversion factor of $31.90 = $163.12

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

Policy adjuster

To encourage access to maternity services and family planning services, the Department increases fees for these codes. This is done by a "policy adjuster" that increases the fee by 10%. For example, the July 2002 fee for a normal delivery and associated care (59400) was calculated as follows:

38.416 RVUs x policy adjustor of 1.10 x conversion factor of $31.90 = $1,348.02

Global periods

For many surgical services and maternity services, the fee covers both the service and all related care within a specified "global" period. For almost all such codes, the global periods used by Medicaid are identical to those used by Medicare, but in cases of differences the Medicaid policy applies. See the *Billing Procedures* chapter in this manual for more information on global periods.

Professional and technical components

Providers must take extra care in billing codes that have global periods or are divided into technical and professional components.

Many imaging services as well as some other diagnostic services are divided into the technical component (performing the test) and the professional component (interpreting the test). A practitioner who only performs the test would bill the service with modifier TC; a practitioner who only interprets the test would bill with modifier 26; and a practitioner who performs both components would bill the code without a modifier. (Performance of both components is called the global service.) The fee schedule has separate fees for each component and for the global service. Consider a chest x-ray (71010) as an example:

71010-TC: 0.409 RVUs x conversion factor of $31.90 = $13.05
71010-26: 0.231 RVUs x conversion factor of $31.90 = $7.37
71010: 0.640 RVUs x conversion factor of $31.90 = $20.42

Other modifiers

Under the RBRVS fee schedule, certain other modifiers also affect payment. As of July 2002, these are shown in the following table.

How Modifiers Change Pricing

- Modifiers may not be applicable for all services. For services paid via the RBRVS fee schedule, the fee schedule shows the list of services for which modifiers 26, TC, 50, 51, 62, 66 and 80 apply.
- If a modifier does not appear in this list, then it does not affect pricing.
- The list shows summary modifier descriptions. See the CPT-4 and HCPCS Level II coding books for the full text.

Modifier	Definition	How it affects payment
21	Prolonged evaluation and management	This service is paid at 110% of the fee.
22	Unusual procedural service	Pay by report
26	Professional component	For services paid via the RBRVS fee schedule, see the specific service. For other services, payment equals 40% of the fee.
47	Anesthesia by surgeon	Pay by report
50	Bilateral procedure	The procedure is paid at 150% of the fee.
51	Multiple procedures	Each procedure is paid at 50% of the fee.
52	Reduced service	The service is paid at 50% of the fee.
53	Discontinued procedure	The service is paid at 50% of the fee.
54	Surgical care only	The service is paid at 75% of the fee.
55	Postoperative management only	The service is paid at 25% of the fee.
56	Preoperative management only	The service is paid at 25% of the fee.
62	Two surgeons	Each surgeon is paid at 62.5% of the fee.
66	Surgical team	Each surgeon is paid by report.
80	Assistant surgeon	The service is paid at 16% of the fee.
81	Minimum assistant surgeon	The service is paid at 16% of the fee.
82	Assistant surgeon; qualified resident surgeon not available	The service is paid at 16% of the fee.
90	Reference laboratory	Modifier not allowed
AD	Medical supervision of more than four concurrent anesthesia procedures	Each service is paid at 52.5% of the fee.
AS	Physician assistant, nurse practitioner or clinical nurse specialist as assistant at surgery	The service is paid at 16% of the fee.
QK	Medical supervision of 2-4 concurrent anesthesia procedures	Each service is paid at 52.5% of the fee.
QX	Certified registered nurse anesthetist service: medically directed by MD	Each service is paid at 52.5% of the fee.
QZ	Certified registered nurse anesthetist service without medical direction	The modifier does not reduce the fee, but a professional differential of 90% is applied due to provider type. See *Professional differentials* in this chapter.
SA	Nurse practitioner	Payment equals 90% of the fee for some services but 100% for others. See *Professional differentials* in this chapter.
SB	Nurse midwife	Payment equals 90% of the fee for some services but 100% for others. See *Professional differentials* in this chapter.
TC	Technical component	For services paid via the RBRVS fee schedule, see the specific service. For other services, payment equals 60% of the fee.

Professional differentials

For some services, mid-level practitioners are paid at 90% of the fee schedule amount. For other services, however, mid-level practitioners are paid at 100% of the fee schedule amount. The 100% services include immunizations, family planning, drugs paid via HCPCS Level II codes, services to clients under age 21 (i.e., Well Child EPSDT services), lab and pathology services, radiology, cardiography and echocardiography (per ARM 37.86.205(6)).

Psychiatrists are paid 125% of the fee schedule for mental health and related services. Licensed professional counselors and social workers are paid 62.5% of the fee schedule.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

Charge cap

For the services covered in this manual, Medicaid pays the lower of the established Medicaid fee or the provider's charge.

Payment by report

About 4% of services covered by the RBRVS fee schedule do not have fees set for them; these services are typically rare or vaguely specified in the coding guidelines. For these services, payment is set at a percentage of the provider's charge. As of July 2002 the percentage was 51%; the Department typically reviews this percentage each July.

Bundled codes

A few services are covered by the Department but have a fee of zero, meaning that payment for the service is considered bundled into the payment for services that are usually provided with it. Examples are removal of sutures (15850), pulse oximetry (94760) and post-operative follow-up visits (99024). Because these services are covered by Medicaid, providers may not bill clients for them on a private pay basis.

Status codes

The RBRVS fee schedule includes status codes that show how each service is paid. The list of status codes is based on that used by Medicare, as shown in the following table.

Table A
Medicare and Medicaid RBRVS Status Values

Medicare Status		Medicaid Status	
A	Active code paid using RVUs	A	Active code paid using RVUs set by Medicare
B	Bundled code	B	Bundled code
C	Carrier determines coverage and payment	C	Pay by report
D	Deleted code	D	Discontinued code
E	Excluded from fee schedule by regulation		[Medicaid reviews each code and usually assigns A, K or X status]
F	Deleted/discontinued code; no grace period	D	Discontinued code
G	Use another code; grace period allowed	G	Use another code; grace period set code-by-code
H	Modifier deleted		[Assigned to D status]
I	Use another code; no grace period		[Assigned to G status]
		J	Anesthesia code
		K	Active code paid using RVUs set by Medicaid
		L	Not paid via RBRVS. See lab fee schedule.
		M	Not paid via RBRVS. See non-RBRVS fee schedule.
N	Excluded from fee schedule by policy		[Medicaid reviews each code and usually assigns A, K or X status]
P	Bundled or excluded		[Medicaid reviews each code and usually assigns B or X status]
R	Restricted coverage		[Medicaid reviews each code and usually assigns A or K status]
T	Injections		[Medicaid reviews each code and usually assigns A status]
X	Excluded from fee schedule by statute	X	Not covered

Notes:
- Medicare publishes RVUs for codes that have Medicare status values of R and sometimes publishes RVUs for codes with status values of E, N or X.
- Medicare uses the label “injections” for status T but now uses the code for other situations (e.g., pulse oximetry) where Medicare pays for the service only if no other service is performed on the same day.

Anesthesia Services

The following payment method is used for anesthesia services (00100-01999), regardless of whether the service is billed by an anesthesiologist or another professional. Though the method differs from the RBRVS payment method, the two methods are linked and contain similar provisions.

Time units

A unit of time for anesthesia is 15 minutes, though Medicaid does pay for partial units. Providers enter the number of minutes on the claim; the claims processing contractor then converts the minutes to time units.

Base units

Base units are adopted by Medicaid from the schedule of base units used by Medicare, which in turn is reflects base units calculated by the American Society of Anesthesiologists. Providers do not enter the number of base units on the claim.

Fee calculation

For a particular service, Department payment is calculated as follows:

(Time units + base units) x anesthesia conversion factor = payment

For anesthesia for a wrist operation (01820), for example, the number of base units is 3. If the anesthesiologist spends 60 minutes with the patient then payment would be:

[4 + 3] x conversion factor of $26.25 = $183.75

The only exceptions are several codes for which time units do not apply. These codes are paid via the RBRVS fee schedule, with the relative values being set by the Department so that the fee equals the number of anesthesia base units x the anesthesia conversion factor.

Transitional conversion factor

Although the terminology is similar to the RBRVS, the two sets of relative values represent two different ways of comparing services. Accordingly, the Medicare program uses a different conversion factor for anesthesia services; in Montana in 2002 it is $15.11. Because of the legislatively mandated transition described above, the Medicaid conversion factor in July 2002 is $26.25. Without the transition, the Medicaid conversion factor would be $15.11.

Policy adjustor

Anesthesia codes for maternity and family planning procedures are paid 10% more than they would otherwise be paid.

Modifiers

Payment for anesthesia services is affected by the modifier pricing rules shown in the accompanying table; take note of the modifiers for anesthesia care provided under medical supervision. Medicaid follows Medicare in not paying extra for the patient status modifiers P1 to P6.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

When billing Medicaid for anesthesia services, enter the number of minutes in the "Units" field of the CMS-1500 claim form.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

Professional differentials

In general, certified registered nurse anesthetists (CRNAs) receive 90% of the fee that a physician would receive for the same case. The exception is that CRNAs receive 100% of the fee for immunizations, family planning, drugs paid via HCPCS Level II codes, services to clients under age 21 (i.e., Well Child EPSDT services), lab and pathology services, radiology, cardiography and echocardiography (per ARM 37.86.205(6)).

Charge cap

The Department pays the lower of the provider's charge and the amount as calculated above.

Payment by report

Base units have not been developed for unlisted anesthesia services. These services are paid at a percentage of charges; in July 2002 the percentage was 51%.

Clinical Lab Services (ARM 37.85.212)

In general, Medicaid pays the same fees for clinical lab services as Medicare does in Montana. If a Medicare fee is not available for a lab test covered by Medicaid, then payment is calculated by looking at the average charge and the amounts paid by other payers.

Vaccines and Drugs Provided Within the Office

Many vaccines are available for free to physician offices through the Vaccines for Children (VFC) program. For more information on how to obtain these vaccines, call (406) 444-5580. For these vaccines, the Department does not pay separately. Medicaid does pay for the administration of the vaccine, however. For more information, see the *Billing Procedures* chapter in this manual.

Medicaid pays for vaccines not available through the VFC program, and for other drugs that have to be administered within the office or clinic setting. Medicaid pays average wholesale price less 15% for drugs. Average wholesale price is calculated by National Drug Code, a detailed coding system that is not shown on CMS-1500 bills. Instead, the bills show HCPCS Level 2 codes; almost all drugs are coded in the J series (for example, J2345). When a J code closely matches the NDC code for a particular drug, Medicaid pays for the drug directly. For other J codes, however, the claims processing system denies the line and requests that the provider send the NDC or invoice to the Department so that payment may be calculated.

How Cost Sharing Is Calculated on Medicaid Claims

Client cost sharing fees are a set dollar amount per visit (see the *Billing Procedures* chapter, *Client Cost Sharing,* for more information and a chart showing cost sharing amount by provider type). The client's cost sharing amount is shown on the remit-

tance advice and deducted from the Medicaid allowed amount (see the *Remittance Advices and Adjustments* chapter in this manual). For example, a physician removes a bunion from a client's foot (28290) in her office. The Medicaid allowed amount in July 2002 for this procedure is $456.71. The client would owe the physician $4.00 for cost sharing, and Medicaid would pay the provider the remaining $452.71.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

How Payment Is Calculated on TPL Claims

When a client has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability or TPL. In these cases, the other insurance is the primary payer (as described in the C*oordination of Benefits* chapter of this manual), and Medicaid makes a payment as the secondary payer. For example, a mid-level practitioner provides a Level 2 office visit (99212) to a client who also has insurance through her job. The client's other insurance is billed first and pays $24.25. The Medicaid allowed amount for this service is $28.90. The amount the other insurance paid ($24.25) is subtracted from the Medicaid allowed amount ($28.90), leaving a balance of $4.65, which Medicaid will pay on this claim.

Total payment to the provider from all sources may not exceed the Medicaid allowed amount.

How Payment Is Calculated on Medicare Crossover Claims

When a client has coverage from both Medicaid and Medicare, Medicare is the primary payer as described in the *Coordination of Benefits* chapter of this manual. Medicaid then makes a payment as the secondary payer. For the provider types covered in this manual, Medicaid's payment is calculated so that the total payment to the provider is either the Medicaid allowed amount less the Medicare paid amount or the sum of the Medicare coinsurance and deductible, whichever is lower. This method is sometimes called "lower of" pricing. The following scenarios are examples of how a Medicare crossover claim is paid. Medicaid incurment is not considered in the following examples. These are only examples and may not reflect current rates.

Summary of Crossover Payment Scenarios

Scenario	Client Has Met Medicare Deductible	Medicare Paid Amount Is Less Than Medicaid Allowed Amount	Mental Health Service
1	Yes	Yes	No
2	No	Yes	No
3	Yes	No	No
4	No	Yes	No
5	Yes	Yes	Yes

Scenario 1: Dually eligible client, Medicare paid amount is lower than Medicaid allowed amount, client has already met Medicare deductible.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

Scenario 1

$ 32.81 Medicare allow.
x 80% Medicare rate
$ 26.25 Medicare paid

$ 32.81 Medicare allow.
- 26.25 Medicare paid
$ 6.56 Medicare coinsurance

$ 28.90 Medicaid allow.
- 26.25 Medicare paid
$ 2.65

$2.65 < $6.56
$2.65 Medicaid pays

A physician provides a Level 2 visit in her office to a client who is eligible for both Medicare and Medicaid. The client has already met Medicare's requirement for a $100 deductible per year. The Medicare allowed amount for this service (99212) is $32.81. As usual, the Medicare program pays the physician 80% of this amount, or $26.25. The client would be personally responsible for the balance (or coinsurance) of $6.56, except that he has Medicaid as secondary coverage.

Medicaid's allowed amount for this service is $28.90. Because Medicare already paid $26.25, that would leave a difference of $2.65. Medicaid then compares the coinsurance amount ($6.56) to the Medicaid balance ($2.65) and pays the lower of the two amounts. The provider will receive $2.65 from Medicaid for this claim.

Scenario 2: Dually eligible client, Medicare paid amount is lower than Medicaid allowed amount, client has not met Medicare deductible.

Providers cannot bill Medicaid clients for the difference between charges and the amount Medicaid paid.

This scenario is the same as Scenario 1, except that the client has not yet met his $100 Medicare deductible. The Medicare allowed amount is $32.81, but because that amount is applied to the client's deductible, Medicare pays zero. The Medicaid allowed amount is $28.90. Medicaid will pay the lower of $32.81 and $28.90. Medicaid will pay the provider $28.90 for this claim.

Scenario 2

$ 32.81 Medicare allowed
- 32.81 Applied to deductible
$ 0.00 Medicare paid

$ 28.90 Medicaid allowed
- 0.00 Medicare paid
$ 28.90

$28.90 < $32.81
$28.90 Medicaid pays

Scenario 3: Dually eligible client, Medicare paid amount is higher than Medicaid allowed amount, client has met Medicare deductible.

A physician provided a Level 4 office visit (99214) to a client who is eligible for Medicare and Medicaid. The Medicare allowed amount is $72.01, which Medicare pays at 80% for $57.61. This leaves the client with a $14.40 Medicare coinsurance.

Scenario 3

$ 72.01 Medicare allow.
x 80% Medicare rate
$ 57.61 Medicare paid

$ 72.01 Medicare allow.
- 57.61 Medicare paid
$14.40 Medicare coinsurance

$ 50.66 Medicaid allow.
- 57.61 Medicare paid
$ -6.95 Negative value = 0

$0 < $14.40
$0 Medicaid pays

The Medicaid allowed amount is $50.66. Because Medicare paid $57.61, this would leave a difference of $-6.95. Medicaid considers this negative value equal to $0. Medicaid then compares the coinsurance balance ($14.40) to the Medicaid balance ($0) and pays the lower of the two amounts. Medicaid would pay the provider $0.00 for this claim.

Scenario 4: Dually eligible client, Medicare paid amount is lower than Medicaid allowed amount, client has not met Medicare deductible.

Scenario 4

$136.09 Medicare allow.
-100.00 Medicare deductible
$ 36.09 Medicare balance

$36.09 Medicare balance
x 80% Medicare rate
$28.87 Medicare paid

$36.09 Medicare balance
-28.87 Medicare paid
$ 7.22 Medicare coinsurance

$100.00 Medicare deductible
+ 7.22 Medicare coinsurance
$107.22

$163.12 Medicaid allow.
- 28.87 Medicare paid
$ 134.25

$107.22 < $134.25
$107.22 Medicaid paid

An otolaryngologist performs a tympanostomy on a client who is eligible for both Medicare and Medicaid. The client has not yet met his $100 Medicare deductible. The Medicare allowed amount for this service (69436) is $136.09. Since the client owes $100 for the deductible, Medicare pays 80% of the remaining $36.09 ($28.87), leaving the client with a Medicare coinsurance of $7.22.

Medicaid considers the $100 that was applied to the client's Medicare deductible and adds it to the $7.22 coinsurance for a total of $107.22. Medicaid then subtracts the amount Medicare paid ($28.87) from the Medicaid allowed amount ($163.12) for a total of $134.25 Medicaid compares the $107.22 to the $134.25, and pays the lower of the two amounts. Medicaid will pay the provider $107.22 for this claim.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

Scenario 5: Mental health service, dually eligible client, Medicare allowed amount is lower than Medicaid allowed amount, client has met Medicare deductible.

A psychiatrist provides psychotherapy with medical evaluation and management (90805) for a client who is eligible for both Medicare and Medicaid and has already met the Medicare deductible. The Medicare allowed amount for this procedure is $69.14. Medicare calculates the payment amount for mental health services at 62.5% of 80%, so Medicare paid $34.57. The Medicare allowed amount ($69.14) less the Medicare paid ($34.57) leaves the client with a $34.56 Medicare coinsurance balance.

Scenario 5

$ 69.14 Medicare allow.
x 80% Medicare rate
$ 55.31
x 62.5% Mental health rate
$ 34.57 Medicare paid

$69.14 Medicare allow.
- 34.57 Medicare paid
$ 34.56 Medicare coinsurance

$ 80.71 Medicaid allow.
- 69.14 Medicare allow.
$ 11.57

$11.57 < $34.56
$11.57 Medicaid paid

Medicaid subtracts the Medicare allowed ($69.14) from the Medicaid allowed amount ($80.71) for a balance of $11.57. Medicaid compares the $11.57 to the client coinsurance ($34.56), and pays the lower of the two. Medicaid will pay $11.57 for this claim.

Other Department Programs

The payment method described in this chapter also applies to services provided under the Mental Health Services Plan; as noted above, psychiatrists receive 125% of the fee schedule for designated mental health services. The payment method does not apply to services provided under the Children's Health Insurance Plan.

Appendix A: Forms

- ***Montana Medicaid /MHSP/CHIP Individual Adjustment Request***
- ***Medicaid Recipient/Physician Abortion Certification (MA-37)***
- ***Informed Consent to Sterilization (MA-38)***
- ***Medicaid Hysterectomy Acknowledgment (MA-39)***
- ***Request for Drug Prior Authorization***
- ***Montana Medicaid Claim Inquiry Form***
- ***Paperwork Attachment Cover Sheet***

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

_____
Name

_____
Street or P.O. Box

_____
City **State** **Zip**

2. CLIENT NAME

_____

3. INTERNAL CONTROL NUMBER (ICN)

_____

4. PROVIDER NUMBER

_____

5. CLIENT ID NUMBER

_____

6. DATE OF PAYMENT _____

7. AMOUNT OF PAYMENT $ _____

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

MA-037
(REV 08/98)

MEDICAID RECIPIENT/PHYSICIAN ABORTION CERTIFICATION

MEDICAID CLAIMS FOR ABORTION SERVICES WILL NOT BE PAID UNLESS THIS FORM IS COMPLETED IN FULL AND A COPY IS ATTACHED TO THE MEDICAID CLAIM FORM.

Recipient Name:_____ Provider Name: _____

Part I, II or III must be completed and the physician completing the procedure must sign below.

I. IF THE ABORTION IS NECESSARY TO SAVE THE RECIPIENT'S LIFE, THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

In my professional opinion, recipient suffers from a physical disorder, physical injury or physical illness (or life-endangering physicial condition caused by or arising from the pregnancy itself) that would place the recipient in danger of death unless an obortion is performed.

(attach additional sheets as necessary)

II. IF THE PREGNANCY RESULTED FROM RAPE OR INCEST, THE FOLLOWING MUST BE COMPLETED BY THE RECIPIENT AND PHYSICIAN:

RECIPIENT CERTIFICATION: I Hereby certify that my current pregnancy resulted from an act of rape or incest.

PHYSICIAN CERTIFICATION: If the pregnancy resulted from rape or incest, the physician must mark one of the following and sign below:

___ a. The recipient has stated to me that she has reported the rape or incest to a law enforcement or protective services agency having jurisdiction in the matter or, if the patient is a child enrolled in a school, to a school counselor; or

___ b. Based upon my professional judgement, the recipient was and is unable for physical or psychological reasons to report the act of rape or incest.

III. IF THE ABORTION IS MEDICALLY NECESSARY BUT THE RECIPIENT'S LIFE IS NOT IN DANGER, THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

In my professional opinion, an abortion is medically necessary for the following reasons:

(attach additional sheets as necessary)

PHYSICIAN SIGNATURE: _____ **DATE:** _____

THE INFORMATION CONTAINED IN THIS FORM IS CONFIDENTIAL. THIS INFORMATION IS PROVIDED FOR PURPOSES RELATED TO ADMINISTRATION OF THE MEDICAID PROGRAM AND MAY NOT BE RELEASED FOR ANY OTHER PURPOSE WITHOUT THE WRITTEN CONSENT OF THE RECIPIENT.

DPHHS-MA-38
(Rev. 8/98)

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
INFORMED CONSENT TO STERILIZATION

Medicaid Approved

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____. When I first asked for
(Doctor or Clinic)
the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care to treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected those alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

I am at least 21 years of age and was born on _____
(month) (day) (year)

I, _____, hereby consent of my own free will to be sterilized by _____
(Doctor)

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health & Human Services or Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____
(Signature) **(Date)**

You are requested to supply the following information, but it is not required. *Race and ethnicity designation (please check):*

- ☐ American Indian or Alaskan Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
(Interpreter) **(Date)**

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed
(name of individual)
the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is as least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____
(Signature of person obtaining consent) **(date)**

_____
(Facility)

_____
(Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon
_____
(Name of person being sterilized)
on _____
(date of sterilization operation)
I explained to him/her the nature of the sterilization operation _____, the fact that it is
(specify type of operation)
intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At lease thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
- ☐ Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery:

(describe circumstances):_____
_____

_____
(Physician) **(Date)**

DISTRIBUTION: 1 - patient; 1 - provider (physician, hospital, etc.); 1 - fiscal agent with claim

Instructions for Completing the *Informed Consent to Sterilization* (MA-38)

- No fields on this form may be left blank, except the interpreter's statement.
- This form must be legible, accurate, and revisions are not accepted.
- Do not use this form for hysterectomies (see following *Hysterectomy Acknowledgment* form.)

Consent to Sterilization (complete at least 30 days prior to procedure)

1. Enter the doctor's name or clinic name.
2. Enter the name of the sterilization procedure (e.g., tubal ligation, vasectomy, etc.).
3. Enter the client's date of birth in month/day/year format. The client must be at least 21 years old at the time of consent.
4. Enter the client's full name. Do not use nicknames. The name should match the client's name on the Medicaid eligibility information.
5. Enter the name of the physician who will perform the procedure.
6. Enter the name of the specific procedure (method) to be used.
7. Have the client sign and date the form. **This date must be at least 30 days before the sterilization procedure is to be performed** (see *Covered Services* for exceptions).

Interpreter's Statement

Complete this section only if the client requires an interpreter because of blindness, deafness, or inability to speak the language. In these cases interpreter services must be used to assure that the client clearly understands the concepts of the informed consent.

1. Identify the manner the interpreter used to provide the explanation. (e.g., Spanish, sign language, etc.)
2. Have the interpreter sign and date the form. This date should be the same as the date the client signs the form.

Statement of Person Obtaining Consent

1. Enter the client's name.
2. Enter the name of the sterilization procedure.
3. Enter the signature and date of the person who explained the sterilization procedure to the client and obtained the consent.
4. Enter the name of the facility where consent was obtained, such as clinic name.
5. Enter the address of the facility where the consent was obtained.

Physician's Statement

This section must be completed by the attending physician on or after the date the procedure was performed.

1. Enter the name of the client.
2. Enter the date the procedure was performed. This date and the date of service on the claim must match.
3. Enter the name of the procedure.
4. Use the space under *Instructions for use of alternative final paragraphs* to explain unusual situations, or attach a letter to explain the circumstances. In cases of premature delivery, this must include the client's expected date of delivery. In cases of emergency abdominal surgery, include an explanation of the nature of the emergency.
5. The Physician signs and dates on or after the date of the procedure.

If the physician signs and dates this section prior to the sterilization procedure, the claims will be denied. If the form was filled out after the sterilization but was dated incorrectly, the physician must attach a written explanation of the error. This written explanation must be signed by the physician. Copies of the letter will need to be supplied to all other providers involved with this care before their claims will be paid.

The attending physician must complete the second *alternative final paragraphs* of the Physician's Statement portion of the consent form in cases of premature deliver or emergency abdominal surgery. In cases of premature delivery, the expected delivery date must be completed in this field as well.

DPHHS-MA-039
(Rev. 9/05)

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

MEDICAID HYSTERECTOMY ACKNOWLEDGMENT

A. RECIPIENT ACKNOWLEDGMENT STATEMENT

I certify that prior to the surgery (hysterectomy), I received both orally and in writing information which explained that I would become permanently sterile and that I would be incapable of reproducing children after the surgery is completed.

Signature of Recipient: _____ Date: _____

Signature of Representative (If Required):_____ Date: _____

PHYSICIAN ACKNOWLEDGMENT STATEMENT

I certify that prior to performing the surgery, I advised _____ *(Name of Recipient)* both orally and in writing that the surgical procedure known as a hysterectomy would render her permanently sterile and that she would be incapable of reproducing children after the surgical procedure is completed. I also certify that this procedure is being done primarily for medical reasons other than sterilization.

Signature of Physician: _____ Date: _____

SIGNATURE OF INTERPRETER (If Required)

Signature of Interpreter: _____ Date: _____

B. STATEMENT OF PRIOR STERILITY

I certify that _____ *(Name of Recipient)* was already sterile and unable to bear children at the time the hysterectomy or other procedure capable of causing sterility was performed. The cause of this recipient's sterility was: _____

_____

_____

Signature of Physician: _____ Date: _____

C. STATEMENT OF LIFE THREATENING EMERGENCY

I certify that the hysterectomy or other sterility causing procedure performed on _____ *(Name of Recipient)* was completed under a life threatening emergency situation in which prior acknowledgment was not possible. The nature of the emergency was _____

_____

_____

Signature of Physician: _____ Date: _____

This form may also be used as a substitute for the sterilization consent form for sterilization procedures where the patient is already sterile and for sterilization procedures (i.e., salpingo-oophorectomy, orchiectomy) done only for medical reasons. With these cases, replace "hysterectomy" with the appropriate procedure name.

Instructions for Completing the *Medicaid Hysterectomy Acknowledgment* Form (MA-39)

Complete only one section (A, B, or C) of this form. The client does not need to sign this form when sections B or C are used. This form may be used as a substitute for the *Informed Consent to Sterilization* form for sterilization procedures where the client is already sterile, and for sterilization procedures (i.e. salpingo-oophorectomy, orchiectomy, etc.) done only for medical reasons. In these cases, replace the word "hysterectomy" with the appropriate procedure name.

A. Recipient Acknowledgment Statement

This section is used to document that the client received information about the hysterectomy (or other sterilization-causing procedure such as salpingo-oophorectomy or orchiectomy) before it was performed. The client and the physician must complete this portion of the form together (with an interpreter if applicable) prior to the procedure. Do **not** use this section for cases of prior sterility or life-threatening emergency.

1. The client or representative must sign and date the form prior to the procedure.
2. Enter the client's name.
3. The physician must sign and date the form prior to the procedure.
4. If interpreter services are used, the interpreter must sign and date the form prior to the procedure.

B. Statement of Prior Sterility

Complete this section if the client was already sterile at the time of the hysterectomy or other sterilization causing procedure (e.g., salpingo-oophorectomy or orchiectomy).

1. Enter the client's name.
2. Explain the cause of the client's sterility (e.g., post menopausal, post hysterectomy, etc.).
3. The physician must sign and date this portion of the form.

C. Statement of Life Threatening Emergency

Complete this section in cases where the *Medicaid Hysterectomy Acknowledgment* could not be completed prior to the surgery because of a life threatening emergency.

1. Enter the client's name.
2. Explain the nature of the life-threatening emergency.
3. The physician must sign and date this portion of the form.

MOUNTAIN-PACIFIC QUALITY HEALTH FOUNDATION

Request for Drug Prior Authorization

Submitter: ☐ Physician ☐ Pharmacy **Please Type or Print**

PATIENT NAME (Last) (First) (Initial)		PATIENT MEDICAID I.D. NUMBER	DATE OF BIRTH
			MONTH DAY YEAR
PHYSICIAN PROVIDER #	PHYSICIAN PHONE #	DATES COVERED BY THIS REQUEST	
		FROM	TO
PHYSICIAN NAME		MONTH DAY YEAR	MONTH DAY YEAR
PHYSICIAN STREET ADDRESS		**MAIL, FAX OR PHONE COMPLETED FORM TO:**	
PHYSICIAN CITY STATE ZIP		**DRUG PRIOR AUTHORIZATION UNIT MOUNTAIN-PACIFIC QUALITY HEALTH 3404 COONEY DRIVE HELENA, MT 59602 (406) 443-6002 or 1-800-395-7961 (PHONE) (406) 443-7014 or 1-800-294-1350 (FAX)**	
PHARMACY PROVIDER NO.	PHARMACY PHONE #		
PHARMACY NAME			
PHARMACY STREET ADDRESS			
PHARMACY CITY STATE ZIP			

DRUG TO BE AUTHORIZED

DRUG NAME	STRENGTH	DIRECTIONS

DIAGNOSIS OR CONDITION TREATED BY THIS DRUG

LEAVE BLANK - PA UNIT USE ONLY

REASON FOR DENIAL OF DRUG PRIOR AUTHORIZATION

IMPORTANT NOTE: In evaluating requests for prior authorization, the consultant will consider the drug from the standpoint of published criteria only. If the approval of the request is granted, this does not indicate that the recipient continues to be eligible for Medicaid. It is the responsibility of the provider of service to establish by inspection of the recipient's Medicaid eligibility card and if necessary, by contact with Consultec to determine if the recipient continues to be eligible for Medicaid.

CURRENT RECIPIENT ELIGIBILITY MAY BE VERIFIED BY CALLING CONSULTEC AT 1-800-624-3958 or 406-442-1837.

APPROVAL OR DENIAL STATUS	DENIAL CODE	THERAPEUTIC CLASS	AUTH ID	DATE OF REQUEST	PRIOR AUTHORIZATION NUMBER

Montana Medicaid Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____

For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Provider number _____	ACS Response: _____
Client number _____	_____
Date of service _____	_____
Total billed amount _____	_____
Date submitted for processing _____	_____
	_____
	_____
Provider number _____	ACS Response: _____
Client number _____	_____
Date of service _____	_____
Total billed amount _____	_____
Date submitted for processing _____	_____
	_____
	_____
Provider number _____	ACS Response: _____
Client number _____	_____
Date of service _____	_____
Total billed amount _____	_____
Date submitted for processing _____	_____
	_____
	_____

Mail to: Provider Relations
P.O. Box 8000
Helena, MT 59604

Fax to: (406) 442-4402

MONTANA
Department of Public Health & Human Services

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: _____

Date of service: _____

Medicaid provider number: _____

Medicaid client ID number: _____

Type of attachment: _____

Instructions:

This form is used as a cover sheet for attachments to electronic claims sent to Montana Medicaid. The *Paperwork Attachment Control Number* must be the same number as the *Attachment Control Number* on the corresponding electronic claim. This number should consist of the provider's Medicaid ID number, the client's Medicaid ID number and the date of service (mmddyyyy), each separated by a dash (9999999-999999999-99999999). This form may be copied or downloaded from our website www.mtmedicaid.org. If you have questions about which paper attachments are necessary for a claim to process, please call Provider Relations at (406) 442-1837 or (800) 624-3958.

Appendix B: Well Child Screen Chart

Rev 09/05

Well Child Screen Recommendations

Child's Name_____ Child's SSN_____ Child's Date of Birth _____

Parent's Name_____ Parent's SSN_____

	Well Child Screen component	Age requirements	Date completed
A.	**Initial/Interval History**		
	Developmental history	all ages	
	Nutritional history	all ages	
	Complete dental history	all ages	
B.	**Assessments**		
	Appropriate developmental screen		
	motor	all ages	
	social	all ages	
	cognitive	all ages	
	speech	all ages	
	Nutritional Screen	all ages	
	Age Appropriate Risk Assessment Screen		
	Emotional	all ages	
	Risky behaviors	all ages	
	Blood Lead	all ages	
	TB	all ages	
C.	**Unclothed Physical Inspection**		
	Height/weight	all ages	
	Head circumference	newborn through 2 years old	
	Standard body systems	all ages	
	Check for signs of abuse	all ages	
	Blood pressure	3 years on	
D.	**Vision Screen**		
	External inspection for gross abnormalities or obvious strabismus	all ages	
	Gross visual acuity with fixation test	birth to 2 years	
	Light sensation with papillary light reflex test	birth to 2 years	
	Observation and report of parent	birth to 2 years	
	Examination of red reflex	all ages	
	Alternate cover test	2 years to 5 years	
	Corneal light reflex	2 years to 5 years	
	Visual acuity using the Illiterate Snellen E chart (or similar)	4 years and over	
	Color discrimination on all boys (once)	5 years and over	
E.	**Hearing Screen**		
	History, physical and developmental assessment	all ages	
	Middle ear exam by otoscopy	all ages	
	Administration of high risk criteria	6 months OR 2 years	
	Assess hearing capability	6 months OR 2 years	
	Administration of puretone audiometry	5 years and over	
F.	**Laboratory Tests (use medical judgment and risk assessment to determine need EXCEPT for blood lead)**		
	Hematocrit or hemoglobin	9-15 months if indicated by risk assessment	
	Urinalysis	if indicated by risk assessment	
	Tuberculin	if indicated by risk assessment	

	Cholesterol	if indicated by risk assessment and age appropriate (8 - 14)	
	Hereditary/metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia)	newborn	
	Blood lead	12 and 24 months and other ages if at risk	
	STD screening	sexually active adolescents	
	Pap smear	sexually active adolescents	
	Other tests as needed		
G.	**Immunizations (the immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP); if the committee has released an updated schedule, that schedule supercedes this one)**		
	Hepatitis B (Hep B)	1 at birth, 2nd by 4 months, 3rd between 6-18 months, and "catch up" at any tiem	
	Diphtheria, tetanus, pertussis (DTaP)	2 mos, 4 mos, 6 mos, 15-18 mos, 4-6 years	
	H. influenza type b (Hib)	2 mos, 4 mos, 6 mos, 12-15 mos	
	Inactivated polio (IPV)	2 mos, 4 mos, 6-18 mos, 4-6 years	
	Pneumococcal conjugate (PCV)	2 mos, 4 mos, 6 mos, 12-15 mos	
	Measles, mumps, rubella (MMR)	12-15 mos, 4-6 years, "catch up" any time	
	Varicella (Var) (if given after 12 years, 2 doses separated by 1 month should be given)	12-18 mos, "catch up" any time	
	Tetanus (Td)	11-12 years, then every 10 years	
H.	**Dental Screen (to be done by medical health provider)**		
	Counseling on oral hygiene	all ages	
	Counseling for non-nutritive habits (thumb-sucking, etc.)	through age 6 years	
	Initial/interval dental history	all ages	
	Oral inspection of mouth, teeth, gums	all ages	
I.	**Discussion and Counseling/Anticipatory Guidance**		
	Address needs and topics appropriate for age level per risk assessment	all ages	

Appendix C

Place of Service Codes

Place of Service Codes

Codes	Names	Descriptions
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service free-standing facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service provider-based facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 free-standing facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 provider-based facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09 - 10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted living facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16 - 19	Unassigned	N/A

Place of Service Codes (continued)

Codes	Names	Descriptions
20	Urgent care facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency room - hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory surgical center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military treatment facility	A medical facility operated by one or more of the uniformed services. Military treatment facility (MTF) also refers to certain former U.S. public health service (USPHS) facilities now designated as uniformed service treatment facilities (USTF).
27 - 30	Unassigned	N/A
31	Skilled nursing facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick person, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial care facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35 - 40	Unassigned	N/A
41	Ambulance - land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - air or water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43 - 48	Unassigned	N/A
49	Independent clinic	A location, not part of a hospital and not described by any other place of service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally qualified health center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient psychiatric facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

Place of Service Codes (continued)

Codes	Names	Descriptions
52	Psychiatric facility -partial hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community mental health center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services: screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate care facility/ mentally retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential substance abuse treatment facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric residential treatment center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential substance abuse treatment facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58 - 59	Unassigned	N/A
60	Mass immunization center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive inpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy , occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive outpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63 - 64	Unassigned	N/A
65	End-stage renal disease treatment facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66 - 70	Unassigned	N/A
71	Public health clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.

Place of Service Codes (continued)

Codes	Names	Descriptions
72	Rural health clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73 - 80	Unassigned	N/A
81	Independent laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82 - 98	Unassigned	N/A
99	Other place of service	Other place of service not identified above.

** Revised, effective October 1, 2005

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

270/271 Transactions
The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions
The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions
The ASC X12N request for services review and response used for prior authorization.

835 Transactions
The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions
The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)
The ANSI-accredited standards development organization, and one of the six Designated Standards Maintenance Organizations (DSMO), that has created and is tasked to maintain the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Allowed Amount
The maximum amount reimbursed to a provider for a health care service as determined by Medicaid or another payer. Other cost factors, (such as cost sharing, TPL, or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Ancillary Provider
Any provider that is subordinate to the client's primary provider, or providing services in the facility or institution that has accepted the client as a Medicaid client.

Assignment of Benefits
A voluntary decision by the client to have insurance benefits paid directly to the provider rather than to the client. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Authorization
An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid
Patients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services.*

Cash Option
Cash option allows the client to pay a monthly premium to Medicaid and have Medicaid coverage for the entire month rather than a partial month.

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Children's Health Insurance Plan (CHIP)
This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by BlueCross BlueShield of Montana.

Clean Claim
A claim that can be processed without additional information from or action by the provider of the service.

Client
An individual enrolled in a Department medical assistance program.

Code of Federal Regulations (CFR)
Rules published by executive departments and agencies of the federal government.

Coinsurance
The client's financial responsibility for a medical bill as assigned by Medicaid or Medicare (usually a percentage). Medicaid coinsurance is usually 5% of the Medicaid allowed amount, and Medicare coinsurance is usually 20% of the Medicare allowed amount.

Conversion Factor
A state specific dollar amount that converts relative values into an actual fee. This calculation allows each payer to adopt the RBRVS to its own economy.

Copayment
The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic
Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost Sharing
The client's financial responsibility for a medical bill assessed by flat fee.

Crossovers
Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles
Clients who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Emergency Services
Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Experimental
A non-covered item or service that researchers are studying to investigate how it affects health.

Fiscal Agent
ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Full Medicaid
Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment
A lump sum debit or credit that is not claim specific made to a provider.

Indian Health Service (IHS)
IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment
A request for a correction to a specific paid claim.

Investigational
A non-covered item or service that researchers are studying to investigate how it affects health.

Kiosk
A "room" or area in the Montana Virtual Human Services Pavilion (VHSP) web site that contains information on the topic specified.

Mass Adjustment
Request for a correction to a group of claims meeting specific defined criteria.

Medicaid
A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medicaid Eligibility and Payment System (MEPS)
A computer system by which providers may access a client's eligibility, demographic, and claim status history information via the internet.

Medically Necessary
A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or

suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare
The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)
This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

Mentally Incompetent
According to CFR 441.251, a mentally incompetent individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

Minimal Services
According to CPT 2001, when client's visit does not require the presence of the physician, but services are provided under the physician's supervision, they are considered minimal services. An example would be a patient returning for a monthly allergy shot.

Montana Breast and Cervical Cancer Treatment Program
This program provides Basic Medicaid coverage for women who have been screened through the Montana Breast and Cervical Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a pre-cancerous condition.

Mutually Exclusive Code Pairs
These codes represent services or procedures that, based on either the CPT-4 definition or standard medical practice, would not or could not reasonably be performed at the same session by the same provider on the same patient. Codes representing these services or procedures cannot be billed together.

PASSPORT To Health
A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Prior Authorization (PA)
The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-pay
When a client chooses to pay for medical services out of his or her own pocket.

Protocols
Written plans developed by a public health clinic in collaboration with physician and nursing staff. Protocols specify nursing procedures to be followed in giving a specific exam, or providing care for particular conditions. Protocols must by updated and approved by a physician at least annually.

Provider or Provider of Service
An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

Qualified Medicare Beneficiary (QMB)
QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Reference Lab Billing
Reference lab billing occurs when a Medicaid provider draws a specimen and sends it to a "reference lab" for processing. The reference lab then sends the results back to the Medicaid provider and bills the provider for the lab service. The Medicaid provider is then expected to bill Medicaid for the lab service. Medicaid does not cover lab services when they are billed by the referring provider.

Relative Value Scale (RVS)
A numerical scale designed to permit comparisons of appropriate prices for various services. The RVS is made up of the relative value units (RVUs) for all the objects in the class for which it is developed.

Relative Value Unit
The numerical value given to each service in a relative value scale.

Remittance Advice (RA)
The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Resource-Based Relative Value Scale (RBRVS)
A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.

Retroactive Eligibility
When a client is determined to be eligible for Medicaid effective prior to the current date.

Routine Podiatric Care
Routine podiatric care includes the cutting or removing of corns and calluses, the trimming and debridement of nails, the application of skin creams, and other hygienic, preventive maintenance care.

Sanction
The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Special Health Services (SHS)
SHS assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

Specified Low-Income Medicare Beneficiaries (SLMB)
For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down
Clients with high medical expenses relative to their income can become eligible for Medicaid by "spending down" their income to specified levels. The client is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Team Care
A utilization control program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed by a "team" consisting of a PASSPORT PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.

Third Party Liability (TPL)
Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Timely Filing
Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Usual and Customary
The fee that the provider most frequently charges the general public for a service or item.

Virtual Human Services Pavilion (VHSP)
This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. http://vhsp.dphhs.state.mt.us

WINASAP 2003
WINASAP 2003 is a Windows-based electronic claims entry application for Montana Medicaid. This software was developed as an alternative to submitting claims on paper. For more information contact ACE EDI Gateway (see *Key Contacts*).

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